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VOL. XXXVI. NUMBER 1.

January, 1879.

THE

SAINT LOUIS Medical and Surgical JOURNAL.

[ESTABLISHED 1843.]

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THOS. F. RUMBOLD, M. D.,
EDITOR AND PROPRIETOR.

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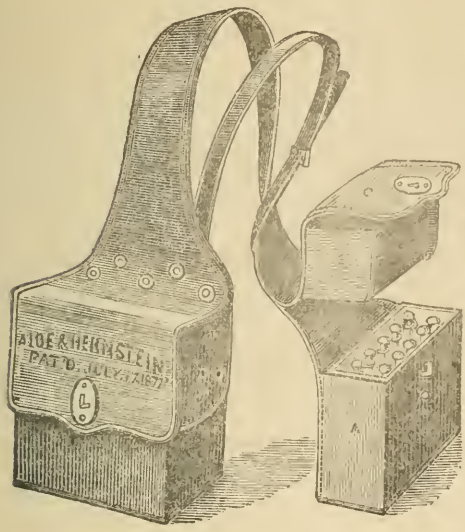

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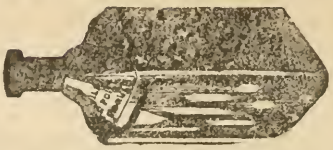
COMPOUND  IODINISED

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☞The Editors hold themselves responsible for the Character of the Contributions, but not for the Opinions expressed in them.

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In support of our claims we invite the attention of the profession to the following points, viz.:

FIRST: In the manufacture of MALTINE the evaporation necessary to reduce it to its great density is conducted in vacuo, at a temperature ranging from 100° to 120° Fahr.; while most manufacturers of Extract of Malt resort to "open pan" or low pressure steam boiling, by neither of which processes can the extract be so produced as to preserve the Diastase, Phosphates and Albuminoids on which its remedial value so greatly depends, and the product is either of a dark color or of low specific gravity, possessing little virtue aside from the saccharine matter which it contains.*

SECOND: Casein, Hordein, Nitrogen, Phosphates, Sulphates, Iron, Magnesia and Potassium (necessary elements in the food of man, and it is only in MALTINE, containing the combined properties of malted *Barley*, *Wheat* and *Oats*, that all these principles can be found in the proper proportions: Extract of Malt (from *Barley* alone) is wanting in some of the most important of these elements.

THIRD: Gluten is the most important principle found in the cereals, and is the only vegetable substance which will, alone, support life for any great length of time. It is composed of three distinct nitrogenous principles, together with fatty and inorganic matters, and is analogous to animal fibrin. MALTINE contains twenty times the quantity of Gluten found in any Extract of Malt.

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We believe that our profession will readily recognize the superiority of MALTINE, and request a trial and comparison of results with any article offered for similar uses.

* As a pure test for Diastase, a few Albumenoids, a small quantity should be put in a test tube or small vial, largely diluted with Water, and heated to the boiling point, when the Albumen, if present, will coagulate, and appear in little flocculent particles throughout the liquid. If the extract remains clear, it is proof that it had already been coagulated by excessive heat, and removed by filtration during the process of manufacturing. Any heat which will coagulate Albumen will inevitably destroy the digestive power of Diastase.

The Nitrogenous constituents of MALTINE have a composition identical with that of the chief constituents of the Blood, and therefore contain nearly every element requisite for the reproduction of the human body.

MALTINE AND ITS COMPOUNDS

can undoubtedly be used with greater success than any other remedy now known, in cases of general and nervous Debility, Indigestion, imperfect Nutrition and deficient Lactation; Pulmonary affections, such as Phthisis, Coughs, Colds, Hoarseness, Irritation of the Mucous Membrane and difficult expectoration; Cholera Infantum and wasting diseases of children and adults; Convalescence from Fevers, and whenever it is necessary to increase the vital forces and build up the system.

WE MANUFACTURE THE FOLLOWING PREPARATIONS, THE FORMULAS AND DOSES OF WHICH ARE GIVEN IN OUR DOSE BOOKS AND ON THE LABEL ATTACHED TO EACH BOTTLE.

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MALTINE, **Ferrated:**

This combination is specially indicated in Anæmia and Chlorosis, and in all cases of defective nutrition where Iron is deficient in the system.

MALTINE **With Phosphates Iron and Quinia:**

A powerful general and nutritive tonic.

MALTINE **With Phos. Iron, Quinia and Strychnia:**

A powerful nutritive, general and nervous tonic.

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MALTINE **With Alteratives:**

In this preparation MALTINE is combined with the most valuable Alteratives known, such as Iodides, Bromides and Chlorides, and will fully meet the requirements of the practitioners in Syphilis, Scrofula and all depraved conditions of the blood.

MALTINE WINE.

This preparation contains all the medicinal and nutritive constitutents of MALTINE, less 60 per cent. of the transformed starch or glucose, which renders the preparation lighter and more acceptable to some stomachs, and is recommended only in such cases.

MALTINE WINE **With Pepsin and Pancreatine:**

(*Each fluid ounce of MALTINE WINE contains* 15 *grains pure PEPSIN and* 15 *grains pure PANCREATINE.*)

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(*Each pint of the above preparation contains* 13 *ounces of MALTINE,* 2 *ounces CARRAGEEN and* 1 *ounce of YERBINE.*)

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The Dose of all preparations of MALTINE and compounds is from a dessert to a tablespoonful.

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This article possesses great advantages over every other ferruginous preparation heretofore introduced, as it is a solution of Iron in as nearly as possible the form in which it exists in the blood. It is a preparation of invariable strength and purity, obtained by a process of dialysation, the Iron being separated from its combinations by endosmosis, according to the law of diffusion of liquids. It has no styptic taste, does not blacken the teeth, disturb the stomach, or constipate the bowels.

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IRON

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PEPTONIC PILLS.

Pepsin, Pancreatin, with Lacto-Phosphate of Lime & Lactic Acid.

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This pill will give immediate relief in many forms of Dyspepsia and Indigestion, and will prove of permanent benefit in all cases of enfeebled digestion produced from want of proper secretion of the Gastric Juice. By supplementing the action of the stomach, and rendering the food capable of assimilation, they enable the organ to recover its healthy tone, and thus permanent relief is afforded. One great advantage of the mode of preparation of these pills is the absence of sugar, which is present in all the ordinary Pepsin and Pancreatin compounds—in this form the dose is much smaller, more pleasant to take, and is less apt to offend the already weak and irritable stomach. The results of their use have been so abundantly satisfactory, that we are confident that further trial will secure for them the cordial Approval of the Medical Profession and the favor of the general public.

Each pill contains one grain of pure Pepsin, and one of pure Pancreatin, which is equivalent to 10 grains of the ordinary or saccharated usually prescribed and dispensed. Physicians will appreciate the great advantage of this mode of administration, the increased benefit to the Dyspeptic being due to a full and effective dose of each, freed from the unnecessary bulk, and really hurtful addition of sugar. A single pill will give immediate relief.

DIRECTIONS.—Take one pill immediately after eating or when suffering from Indigestion, Lump in the Throat or Flatulence. For children reduce the pill to powder and give a fourth or half, according to age.

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It is not a mere stimulant, like the now fashionable extracts of beef, but contains blood-making, force-generating, and life-sustaining properties, pre-eminently calculated to support the system under the exhausting and wasting process of fevers and other acute diseases, and to rebuild and recruit the tissues and forces, whether lost in the destructive march of such affections, or induced by overwork, general debility, or the more tedious forms of chronic disease. It is friendly and helpful to the most delicate stomach, and where there is a fair remnant to build on, will reconstruct the most shattered and enfeebled constitution. It is entirely free from any drugs. Dispensed in 16 oz. bottes.

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"Is a complete representative of lean and fat beef, bone, blood, and muscle. It consists of all the properties which combine in the development of the animal body, which are liquefied by an artificial process, simulating natural digestion, and retaining all of their alimentary values. It contains in their perfection all the natural elements of the meat in their natural quantitative relations, without their extraneous or indigestible properties, and therefore requiring the least possible effort on the part of the stomach for its conversion into chyle, and its immediate absorption by the system.

"This Tonic is free from any drugs or chemicals, and is a great invigorator or recuperant. I have used this preparation in several cases of sickness of a character which enables me to give the most favorable opinion of its great value, in extreme sickness. Some of the cases referred to are hemorrhage of the bowels, typhoid fever, bilious fever, inflammation of the bowels, where the greatest possible prostration was present, and in which I found this meat tonic to accomplish results I could not obtain with any other preparation. It is a gentle stimulant, and allays the peculiar irritation of the stomach, which destroys the appetite in all forms of disease, when the tone of the stomach is destroyed."

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PURE COD LIVER OIL,

Manufactured on the Sea-Shore from Fresh and Selected Livers.

The universal demand for Cod Liver Oil that can be depended upon as strictly pure and scientifically prepared, having been long felt by the Medical Profession, we were induced to undertake its manufacture at the Fishing Stations where the fish are brought to land every few hours, and the Livers consequently are in great perfection.

This Oil is manufactured by us on the sea-shore, with the greatest care, from fresh, healthy Livers, of the Cod only, without the aid of any chemicals, by the simplest possible process and lowest temperature by which the Oil can be separated from the cells of the Livers. It is nearly devoid of color, odor, and flavor—having a bland fish-like, and to most persons, not unpleasant taste. It is so sweet and pure that it can be retained by the stomach when other kinds fail, and patients soon become fond of it.

The secret of making good Cod Liver Oil lies in the proper application of the proper degree of heat; too much or too little will seriously injure the quality. Great attention to cleanliness is absolutely necessary to produce sweet Cod Liver Oil. The rancid Oil found in the market is the make of manufacturers who are careless about these matters.

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Prof. Hays, State Assayer of Massachusetts, after a full analysis of it, says: "It is the best for foreign or domestic use."

After years of experimenting, the Medical Profession of Europe and America, who have studied the effects of different Cod Liver Oils, have unanimously decided the light straw-colored Cod Liver Oil to be far superior to any of the brown Oils.

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Having received many inquiries for our Gelatine-Coated Pills and Granules put up in a form convenient for practitioners, and, not finding any of the ready-made pocket cases in market desirable, we have devised a number of forms and sizes of our own. The number and variety of the formulas of our Pills, together with their ready solubility, have, to a great extent, obviated the necessity of carrying the bulky medicine chest, with its solutions and powders. The cuts here exhibited give a general view of the style of the cases; they are very compact and meant to be carried in the pocket; are of WOOD, HINGED, WITH CLASP; COVERED WITH FINE BLACK MOROCCO and LINED WITH PURPLE VELVET.

To give a better idea of the capacity of the Vials, we append the number of one-eighth grain Morphia, and one and two-grain Quinine Pills, which they will contain; the Cases Nos. 4 and 13 are the only ones which have vials large enough to admit of four or five-grain Pills.

The prices here given include the empty Vials; should they be desired filled with Pills, not procurable at druggists at home, the Pills will be charged at list prices.

This Cut represents Case No. 9.

McKesson & Robbins' Vial Case No. 5. Size, 7 inches x 2⅛ inches x 1⅝ inches; contains twenty-four half-dram Homo. Vials, secured by leather socket. This size is made more especially for the smaller Pills. Vials contain 80 to 90 Granules each; 25 one-grain Pills, or 7 two-grain. Price, $4.00 each.

McKesson & Robbins' Vial Case No. 8. Size, 7 inches x 2½ inches x 1 inch; contains twelve half drachm, Homo. Vials, set in leather sockets. Capacity of Vials, same as No. 5. Price, $3.00 each.

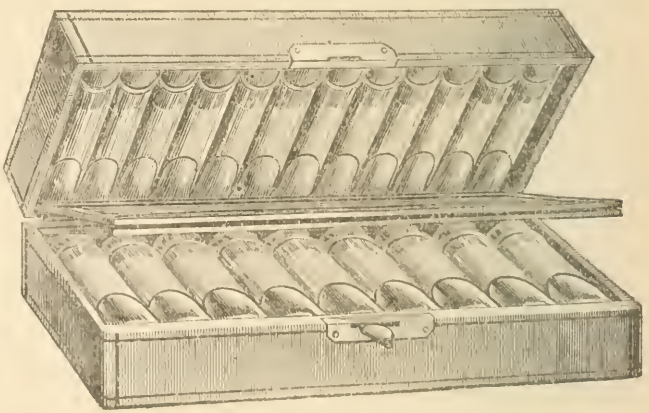
McKesson & Robbins' Vial Case No. 9. Size, 7 inches x 2⅝ inches x 1 inch; contains twelve half drachm heavy flint glass, mushroom-stoppered, Vials; very handsome. Capacity, 75 Granules; 20 one-grain, or 7 two-grain Pills. Price, $3.50 each.

McKesson & Robbins' Vial Case No. 10. Size, 7 inches x 2½ inches x 1⅝ inches; contains twenty-four half-drachm heavy, flint glass, mushroom-stoppered, Vials, secured by leather socket. Capacity of Vials, same as No. 9. Price, $5.00 each.

No. 11.—Same as upper half of cut.

No. 12.—Same style as cut, with the lower half of cut same as upper.

No. 13.—Same as No 12, only the bottles are shorter.



This Cut represents Case No. 4.

McKesson & Robbins' Vial Case No. 4. Size, 6¾ inches long; 3⅛ inches wide; 1⅞ inches thick; contains twenty-one Vials, secured by polished brass spring shields. The Vials are two sizes; nine with a capacity of 175 Granules; 40 one-grain; 21 two-grain, or 7 five-grain Pills, and twelve Vials, holding 85 Granules; 22 one-grain; 9 two-grain, or 5 five-grain Pills. Very convenient for the larger size Pills. Price, $5.00 each.

McKesson & Robbins' Vial Case No. 11. Size, 6¾ inches x 3⅛ inches x 1 inch; contains twelve long-case Vials, secured by neat, polished brass, spring shields. Capacity, 85 Granules; 22 one-grain, or 9 two-grain Pills. Price, $3.50 each.

McKesson & Robbins' Vial Case No. 12. Size, 6¾ inches x 3⅛ inches x 1⅝ inches; contains twenty-four long-case Vials, similar in style to No. 11. Price, $5.00 each.

McKesson & Robbins' Vial Case No. 13. Size, 7 inches x 2½ inches x 1⅝ inches; contains twenty-four short Vials, secured by neat, polished brass, spring shields. Desirable where a narrow case is needed Capacity 75 Granules; 17 one-grain; 6 two-grain, or 4 five-grain Pills. Price, $4.75 each.

THE

SAINT LOUIS

MEDICAL AND SURGICAL

Journal.

VOL. XXXVI——JANUARY, 1879——No. 1.

Original Didactic and Clinical Lectures.

ARTICLE I.

RAILROAD INJURIES AND OTHER CASES. Surgical Clinic of the Missouri Medical College at the City Hospital, by Prof. A. P. LANKFORD, of St. Louis. [Reported for THE JOURNAL.]

AMPUTATION.

GENTLEMEN:—You have seen this patient before. Ten days ago he was admitted to this hospital on account of an injury of the foot. The foot and ankle were caught in the belting of a large wheel, and the entire covering, plantar and dorsal literally and completely torn away and stripped up as high as three inches above the ankle-joint. As it did not seem to be much contused, Dr. Dean, in the true spirit of conservative surgery, carefully replaced it and stitched it up neatly, in the hope of saving the part—one of so much importance to a poor laborer. You will recall that when he was first introduced to you three days afterward, the entire mass was gangrenous—dead or dying. Still, in the hope that some parts might be saved from the general wreck, and become cicatrizing centers in the future, we made free incisions in every direction to insure thorough

drainage, and thus prevent local inflammation and blood-poisoning, and, dressing it antiseptically, directed a sustaining treatment, hoping for the best, but, as I warned you at the time, fearing that the poor fellow might yet have to lose his limb to save his life. This is one of the painful realities of your profession which you have had to confront pretty often recently. You remember the boy Harry, twelve years of age, who one month ago had both legs crushed by the wheels of a railroad coach; and only ten days ago little Edward, only eight years old, whose left ankle and right leg were run over in a similar manner, were brought to this hospital to be cured, limbs and all. Their friends even seemed to expect such a result. In such cases the experienced eye of the surgeon soon detects the incurable mutilation, and decides upon the means best calculated to save life. You will remember that I told you then, with regard to the question of amputation for injury, that the operation as to time was divided into "primary," "intermediary" and "secondary," and that statistics gave conclusive evidence in favor of the first (primary), and next to "secondary," the "intermediary" being attended with the greatest mortality. You know what these expressions mean—that the "primary" is where the operation is performed soon after the injury and before inflammation begins, say within the first thirty-six hours; the "intermediary" is from the beginning and during the inflammation and consequent "traumatic fever," a very uncertain period, its duration being dependent upon the severity of the local process, and the constitution of the patient; and the "secondary" at any time after suppuration has been established. Such a division is not restricted to gunshot wounds, but is convenient and appropriate as a general rule. And let me repeat again, that if amputation is proper or necessary, the sooner it is done the better for the patient. We are taught to always wait for "reaction" if there is "shock," for the return of color to the blanched cheek, warmth to the surface and extremities, pulse to the wrist, and conscious intellection to the bewildered or delirious brain, and many a surgeon has waited in vain. His patient has succumbed when he might have recovered. I speak, of course, relatively. In my opinion there is too little qualification in this broad, comprehensive injunction. It is often better that you should remove at once a crushed and mangled extremity rather than permit it to remain a constant source of profound irritation and consequent

exhaustion of the nerve centers, making reaction impossible. And this seems in accordance with a sound analogy. What is reflex paraplegia but central exhaustion from peripheral irritation, the persistent transmission of impressions by afferent nerves to the spinal ganglia until their power of responding is gone, for a time at least, and motion ceases in the muscles dependent on them. A dislocated womb, a stone in the bladder, ascarides in the rectum, etc., now and then cause loss of power over the lower extremities.

But such agents are mere trifles when compared with the bruised, torn and pulpified nerves of a whole limb, aggravated with every move by the rough fragments, and sharp serrations of broken bone. By removing this the patient exchanges a hopeless, mischievous mass for the smooth cut surfaces and neatly adjusted flaps of a "stump," made comfortable and protected by every possible mechanical contrivance. He can surely bear up under the operation—as well as the presence of the crushed and comminuted limb. The procedure of removal cannot depress in the same space of time more than the contact of the injured, mutilated nerves of the part, and then you have reduced the irritation to a minimum, and the reaction comes on once and for all. On the other hand, you wait, and supposing his vital forces and power of resistance to be sufficient, "reaction" follows the "shock" and is "well established." You now amputate, and the "shock" of the operation succeeds to the "shock" of the injury. In the midst of the excitement and commotion of her first rally from the terrible stroke, and while contemplating the ruins with dismay, and mustering her forces to clear away the rubbish and repair the injury, the system thus all unprepared receives the second blow, and must now recover from two shocks instead of one. You can partly understand how the stunned and half-conscious centers should be little affected when not in a condition to receive and respond to impressions? From such considerations to fortify our experience we concluded that it was best to amputate the little fellow's legs soon after his admission. It was the suggestion of my friend, Dr. Dean, in which I fully concurred; and the result has justified the practice. A double amputation is a severe ordeal at the best, and yet no case, even the most favorable, could proceed more satisfactorily and beautifully. In the other boy's case we followed the same rule with the right leg, but deeming it possible to save the other, yielded to the entreat-

ies of his parents, and made the attempt with the great advantage antiseptics give us. But it was only a few days when its condition unmistakably declared that it was hurt past recovery. Then we amputated, and although his age and strength seemed in his favor in the beginning he has not done nearly so well. The first stump is progressing fairly, but the last operation has been followed by sloughing of one of the flaps, while his general condition has been anything but good for several days. The inference is obvious; for while I shall always, by precept and example, try to impress you with the fact that you should never amputate when it can be avoided, you see in this case an illustration of the value of early and prompt action.

Now, let me again call your attention to the patient whose right lower limb we amputated through the thigh. This was for disease. He had an abscess of the upper end of the tibia, then destructive arthritis, with the leg and lower part of the thigh ploughed up by suppurating tracks. He had been treated in another hospital for abscess of the leg, and not until he came here was it discovered that the joint was involved. Every effort was made to save the extremity, and when we found this hopeless, prepared to excise the knee-joint, although he is much on the shady side of forty. Before beginning the operation he was warned that when the parts were exposed by the preliminary dissection their condition might necessitate amputation. The apprehension was realized, and much against his inclination it was cut off as near the joint as possible, in order to retain good coverings and sound bone for the stump. I pointed this out at the time, spoke of the greatness of conservative surgery (why we had been baffled in it in this case), and then some of the methods by which amputation is performed. And here I will repeat that had it been discovered at first (before he came here) that the abscess of the leg and persistent suppuration following it was symptomatic of the abscess of the upper end of the tibia, his limb might have been saved; and I say this, not in a spirit of criticism, but that you may profit by this fact in the clinical history of the case. Never rest satisfied when dealing with an obstinate suppuration like this has been, until you get to the root of the matter, until you discover the starting point, the first cause, the primary inflammation nest from which it springs, and is, probably, still kept going. Make free incisions and be free with finger and probe (when practicable).

The propriety of amputation being concluded, you have these aims—to preserve the longest leverage consistent with a good covering for the stump. This is the test of the method of operation as to the ultimate result. The last is to provide for thorough drainage, and thus prevent destructive inflammation and blood-poisoning—incidental wound disease. Decided by such considerations we must give the preference to the anterior flap over the others mentioned, and all which you have now seen executed. We cannot always choose, however. Now and then the soft parts are so irregularly torn and bruised that we are glad to get a covering from any direction. Such cases test our ingenuity and resource. Remove all badly injured tissue but no more, always providing for drainage. Preserve a good covering for the stump, but not at the expense of drainage. In operations for the removal of disease there is generally more latitude for choice. When thus favored, make a good covering for the bone, of integument, so shaped that the scar will be upon the side of the limb, instead of in the end of the stump; that it will not be adherent to the bone, but move freely over it; that it will not act as a receptacle, a bag to catch discharges (pus, etc.), but covering and protecting the wound from atmospheric contact, at the same time permit the constant, thorough escape of all fluids. For such an operation we are principally indebted to such men as Carden, Teele and Lane, but as to detail, mainly Carden. The last named gentleman formed "a rounded anterior flap of integument only, without any posterior flaps, and retracting the soft parts somewhat from the bone before dividing it with the saw, thus forming a flat-faced stump with a bonnet of integument to fall over it."

Notwithstanding the admirable results obtained by this gentleman, both in safety to life and the amount of pressure that can be borne by a stump so formed, which he gave to the world about the year 1856, and which has been often corroborated by others since; and, notwithstanding its obvious simplicity and excellence, I must advocate it before you to-day. The only serious objection is the liability of so much integument as the anterior flap inclines to slough from insufficient vascular supply. This may be obviated by making the anterior flap about as long as two-thirds of the diameter of the limb, including all the fascia and a little muscle, if there is any at the point, and a posterior flap of integument about one-third the length of the anterior. This general plan is the best for any portion of the lower ex-

tremity. In both the leg and thigh, so direct your incisions as to provide for the contraction of the long stout muscles of the "calf" and posterior portion of the thigh that all the tension upon the anterior flap covering is prevented. See to it that no pressure upon the stump is made by the dressings, that the circulation is left free and uninterrupted, and surrounded with sufficient warmth. Such precautions obviate the sole objection to this method of amputation. It is not denied that the final result gives the patient a far better stump than the others. Being covered by the natural integument, the scar, upon its posterior aspect, thus eventually becomes, by pressure and friction, thick, brawny and hard, like the palm of the hand and sole of the foot of the laborer—capable of enduring, without pain, the pressure of an artificial limb fitting to the end of the stump, and enabling the patient, finally, to walk without other aid than a cane. Some of them even dispense with this.

During the present course I shall be able to illustrate this to you with more than one patient, even in amputations of the thigh. The scar in the end of the stump and generally adherent to the bone in both the circular and ordinary flap methods, generally makes an artificial limb a most imperfect substitute, worn with difficulty, atended with pain and followed by disease which may require a second amputation. The same general principle may be applied to the upper extremities. Another merit which this method possesses over all others is the facility afforded for antiseptic treatment, upon which the life of the patient, as well as a good stump, may depend. Of the value of antiseptic methods I will speak presently.

We will now give our patient ether and amputate his leg just above the junction of the middle and lower thirds by the method just described. (The patient being completely anæsthetized the amputation was made upon the plan above mentioned. He reacted well. The operation was made in the "carbolic spray," and the stump dressed antiseptically, drainage tubes being left between the flaps.)

[TO BE CONTINUED.]

Original Contributions.

ARTICLE II.

THE HYSTERICAL SIMULATION OF ORGANIC NERVOUS DISEASE. By ALLAN MCLANE HAMILTON, M. D., of New York, Visiting Physician to the Hospital for Epileptics and Paralytics, the Randall's Island Idiot Asylums, etc., New York City.

The connection between certain forms of hysteria and organic nervous diseases of well-established character is beginning to receive the attention it deserves, and the impetus given to this branch of study, especially by Charcot [1] and other French observers, is indicative of its importance. It was this writer who first traced the probable relationship of hysterical contractures and disease of the lateral columns of the spinal cord, and his valuable autopsy established the existence of primary symmetrical sclerosis in a case of this kind. Seguin and myself have observed hysterical symptoms in certain forms of hemiplegia, while the existence of exaggerated emotional states with cerebral tumor have been fully recognized [2]. In cerebral syphilis I have on two occasions found quite pronounced hysterical attacks, which recurred after slight excitations. It is not of these manifestations that I propose at present to speak, for when the diagnosis of organic disease is made, the appearance of hysterical symptoms may only be regarded as interesting clinical features, and rarely affect diagnosis; but when I say that it is possible for organic disease to begin with hysteria, or for hysterical symptoms to counterfeit the true evidences of organic nervous disease so closely as to almost defy detection, I think I do not speak of improbabilities.

During the past three or four years I have occasionally encountered examples of this class which were puzzling in the extreme, and I am convinced that the unwary practitioner may be sometimes easily led into the commission of a blunder. Cases of

1, *Gaz. Hebdomidaire*, 1865, No. 7.

2. *Brain*, April, 1878.

hysterical trouble expressed by disorders of motility, either paralysis, tremor or spasm, are sometimes very difficult to diagnose. A woman of middle age presented herself at the Out-Patient Department of the New York Hospital, several months ago, suffering with a rather violent rythmical tremor of the head and both hands, and accompanied by no abnormality of sensation. This tremor was quite persistent, and was markedly increased in volitional efforts. When she carried her handkerchief to her face, the hand shook more violently as she neared the accomplishment of the act than it did in the beginning. When carefully examined by Dr. Kinnicutt, who was present at her first visit, and myself, there seemed to be a possibility that her disease was a multiple cerebro-spinal sclerosis. Her face bore the particularly anxious expression described by writers upon the subject, and she sat bent forward, her head in advance of her body. There was no festination when she attempted to walk, and, from the absence of other signs, I did not feel at all sure of my diagnosis, but felt confident that there was some organic disease. When she next came, a week later, she was exceedingly emotional, and her movements were the same as before; and to these symptoms was added that of subjective numbness of the fingers. I might mention that the tremor was so violent that her voice was affected, and she talked very much as a person would who was chilled through. At her third visit, her only symptom was the emotional excitement, the tremor having *entirely disappeared*, and she was perfectly quiet until I asked her some question regarding its cessation, when it it returned with redoubled violence; and on my questioning her closely, she became very indignant. A careful examination revealed some left sided ovarian hyperæsthesia. She was, I afterwards learned, committed to an asylum for hysterical insanity. Strangely enough in this case there was atrophy of one optic nerve, and had I noticed this feature earlier, I should have been more ready in the begining to suspect sclerosis as a lesion.

Various forms of hysterical paralysis, especially of a paraplegic form, may simulate the organic varieties very closely. Miss. E. was a patient of this kind who during the existence of hysterical paraplegia presented urinary and rectal disorders, which, if taken into account with her other troubles, might lead a medical man who should see her for the first time to call her ailment somothing more serious than it really was. At this time her loss of

power was complete, and *through disuse* her limbs had become greatly atrophied; indeed there were contractures of the tendinis achillis of both legs, anaesthesia and analgesia, so that a pin might be thrust into the muscular tissue of the leg without producing pain.

For a period of a month there was not only incontinence of urine but involuntary stools as well. At the end of this time the functions of the bladder and rectum became perfectly normal. From the fact that the urine discharged was inoffensive, perfectly clear and quite copious, that there was no ammoniacal odor, and that the stools were watery; that ovarian hyperæsthesia existed, and that before this time a great variety of hysterical symptoms had been expresed, entirely did away with the chance of error in diagnosis.

In other cases the difficulty has been greater, for instance Webb [3] reports a case of hysterical locomotor ataxia which defied successful investigation for some time. The patient was a woman aged 35 years, who had suffered from menstrual troubles for a long period, and with these there were pains of various kinds in the back and legs, with the constricting band and a certain amount of anæsthesia. She had lost control of the bladder and rectum, and the urine contained some albumen. She could not stand and would fall if not supported, and when she walked her feet were thrown out, and there was marked inco-ordination of muscular movements. A year after the commencement of her trouble her fingers became stiff and powerless. When her mind was directed from her condition, her back pain would not be complained of, and she could bear quite decided pressure on the vertebral spines. Somewhat in doubt as to her condition, Dr. Da Costa was called in consultation, and pronounced the case one of hysteria and such a diagnosis was verified by the fact that but feeble contractions followed electric stimulation of the muscles, which is the case in some forms of old hysteria, while in locomotor ataxia there is marked elevated electric irritability. Great improvement immediately followed treatment, which was still more decided when the menses were re-established.

In a hysterical malingerer I have witnessed symptoms which were for a time very suggestive of locomotor ataxia; there was absolutely no atrophy of the optic nerve, however, and there was

3. *Amer. Jour. of the Med. Sciences, 1876, p. 119.*

an assumed loss of power when the patient's muscular strength was tested, and a week after the first examination the whole character of her gait was changed; it becoming a spurious paraplegiform walk instead of an ataxic effort.

Last Fall, in consultation with Dr. J. P. P. White, of New York, I saw a man who presented a remarkable collection of nervous symptoms. He had been rather unsuccessful in some business affairs in the West, and keenly felt his embarrassment. On the way from Chicago he was seized with convulsions of a violent kind, and remained unconscious for some hours. When I visited him at his hotel I found him surrounded by friends who were doing their best to keep him quiet, and the efforts of two strong male nurses were almost insufficient to confine him to the bed. He was a powerful, muscular young man of about thirty-five, showing no evidence of exhaustion, nor disease of any kind. I found him in a condition of opisthotonos, the arc being greater than I had ever witnessed it before. The head was buried in the pillow, his face was flushed and swollen, and he sweated profusely. His eyes were staring and uncovered by the lids, while the pupils were widely dilated. The convulsions, at first tonic, and shortly afterwards clonic, lasted about two minutes and there was afterwards a period of relaxation. The slightest jar of the bed or attempt to arrange the bed clothing precipitated a fresh attack. He had been in this condition for nearly twenty-four hours before I saw him, and had neither eaten nor given any intelligible sign of consciousness, except once, when he called "father," although there was no external appearance of unconsciousness, but the patient rolled his eyes about occasionally, and his face bore an expression which suggested that he desired to communicate, but could not. The case was at first puzzling, and suggested the idea that it might be either tetanus or strychnia poisoning. These were disposed of by the absence of traumatism and endemic influences; by the fact that the temperature was not especially high; that there was no trismus; that his trouble had lasted too long for strychnia poisoning—but the most striking proof of all, in regard to the real nature of the case, was the fact that the convulsions disappeared almost as if by magic when it was said in his hearing that the doctor had pronounced his trouble hysteria, and when he was given a mixture of assafœtida. The supposed rarity of male hysteria in general, and of this kind

in particular, would, in such a case, be likely to throw one off his guard.

There are many other forms of trouble which might be alluded to, but I forbear to weary my readers with their recital. One case, however, is worthy of mention because it is extremely rare. I speak of hysterical chorea. Several cases have recently been recorded, one by Cordly Bradford.[4]

In this case, who was a girl nineteen years of age, there were extensive movements, but none of the facial muscles. There was tenderness of the left ovary, and pressure relieved the irregular movements to some degree. In such cases the chronic movement occurred with well pronounced hysterical symptoms. In a personal example the first manifestations were those of an ordinary chorea, and afterwards there were developed very decided convulsions and other hysteroid symptoms.

Fanny McC. is a cloakmaker nineteen years of age. After a day spent at a picnic, and attended by a great deal of excitement, she became "nervous," irritable, and refused food. A day or two later she began to "twitch," and well marked chorea appeared; not only were her hands affected, but her mouth moved as well. This continued for several weeks; she was meanwhile treated by her family physician. At the end of this time she should have menstruated, but did not, and suffered greatly from pain. The nervous symptoms now underwent a decided change. She became almost maniacal, threatened suicide, and other violence, had hallucinations and disturbed the peace of the family most thoroughly. At the invitation of Dr. Stuyvesant Morris I went to see her, and found her rolling on the floor in a semi-nude condition, talking incoherently, and beating her head against the boards. Her whole body was agitated by exaggerated choreic movements, which were incessant. When I next saw her, her trouble had undergone a change, so far as the mental condition was concerned, but her movements were quite violent. She could talk, but her speech was interrupted and explosive. There was gradual improvement when her uterine condition was treated, and though emotional and excited, she is now much better. There was absolutely nothing in the beginning to indicate the real nature of her chorea, and until the development of her more pronounced symptoms it presented nothing which differed from an ordinary case of chorea.

4. *Br. Med. Jour.*, Oct. 12, 1878.

The development of real organic disease after a continued hysterical condition is, I am sure, quite possible, and I do not fully believe in the frequency of sudden cures after some particular hysterical train of symptoms have lasted for years. From personal observation of one case in particular I have no doubt but that a degeneration of the lateral column has followed hysterical paralysis and contracture of a lower extremity. At first in this case there was an uncomplicated volitional paralysis, an ordinary hysterical paralysis, but disuse of limbs after years spent upon a couch have brought more serious trouble, such as rigidity at the ankle and knee-joint, and deformities overcome only with difficulty by passive motion and retraction of the heel, as well as a very decided tendon reflex, and other peculiar evidences commonly seen in spastic paralysis. As to convulsive affections of hysterical character, I think the literature of hystero-epilepsy furnishes us with enough examples of developed convulsions as a result of the primary trouble to prove the truth of what I suggest. These are but two varieties of confirmed disease, and doubtless there are many others.

In our examination of suspected cases we must be governed by certain peculiar features of hysteria, some of which have been recently discovered. I will not go into the question of the diagnosis of special symptoms, for this would lead to an interminable discussion, but I would call the reader's attention to the fact that in cases of this kind we rarely find any of the more pronounced symptoms of confirmed organic disease. As those which are absent I may allude to cranial nerve paralysis. I do not know of such a condition as hysterical ptosis, though diplopia is an occasional, but very rare symptom, and like many others of the same order, is liable to be a hysterical manifestation. Amaurosis and amblyopia are frequently hysterical, but in neuritis of the optic nerve and its consequences—disk atrophy, choked disk, or other retinal changes—are never found in hysterical subjects, except in rare coincidences. Strabismus may be hysterical, but in connection with other cranial nerve troubles is indicative of serious organic disease. As to pain as a symptom we can say but little, for dysæsthesiæ of various kinds are bewildering, and except for other evidences of disease, it can have alone but little significance. The pure hysterical sensory disturbances are notably the hyperæsthesiæ, and deep pressure does not produce anything like the discomfort of light contact. Atrophy of mus-

cular tissue can only be that which accompanies inactivity, and the atrophy with hysteria is never confined to special groups; so if we find such picked out ("dissecting atrophy" as it were), or if the extensors be alone involved, we need have no trouble in distinguishing true spinal disease from the condition under discussion. The muscles respond invariably to electrical currents in hysteria, unless the paralysis has lasted for a long time, and even then there is always a response of some kind. So disease of the anterior columns of the end may be excluded, in which the electric muscular contracticity is lost.

The convulsions or spasmodic movements of the hysterical affections need not be confounded with those of the well regulated and defined affections which they symptomatize, for the former are decidedly irregular or *bizarre*, and are neither constant, nor as a rule exactly alike at different times. The *chorea* of hysterical origin is too violent, and attended by too much emotional excitement. The *tremor* rarely lasts when the patient's attention is diverted, and the *contractures* disappear when she performs some voluntary movement, which brings her comfort, for instance, when she changes her position.

Coupled with these evidence we must always fully appreciate the sex of the individual, and if a woman we should be more than ever on our guard.

The existence of uterine or other like ovarian disorders and tenderness, should also be taken into account. So too, the false perception of color, the patient often reversing the primary color, saying that everything appears to be of the same hue is suggestive of hysteria. Within a short time I have seen a case in consultation with Dr. Satterlee at the New York Midnight Mission, which at first appeared to be one of specific epilepsy which had passed into the status epilepticus, as the patient had had within a week many epileptical attacks, had been seemingly delirious, had complained of intense headache, and as she was formerly a prostitute the inference of syphilis was quite probable, and more strangely born out by the appearance of an erythema upon the face and chest. She had had vomiting which was apparently cerebral, and when we saw her she complained of intense headache.

The history of irregular menstruation, with very great ovarian tenderness, so great, in fact, that the weight of the bedclothes could hardly be borne, and slight pressure of the hand caused

intolerable pain; the passage of large quantities of limpid urine, the normal dilatation of the pupils, and the appearance of the eyeballs, which were rolled upwards, all tended to remove any suspicion of true epilepsy.

The temperature had not advanced above 100° F., and the pulse was excited to a moderate degree. Her incoherent talk even had a certain connection after all, and then was decided "method in her madness." This patient "saw" only *yellow*, every fabric in the room—our faces, the walls and ceilings, all appeared to her to be of a bright yellow color. She became suddenly well, the marked spots of erythema fading out and remaining absent until a week ago, when her menstrual period again came around, and with it an hysterical attack. The spots on her face and chest reappeared, and remained of a livid color until the nervous excitement subsided.

There are many cases of this kind, to which I have alluded in this paper, which should be carefully and patiently examined before a diagnosis is decided upon and announced, and I believe that numerous examples of so called organic neuroses are supposed to exist, which are after all examples of unusual hysteria.

No. 2 East 33d St., New York.

ARTICLE III.

OBSERVATIONS ON YELLOW FEVER. By A. HAUSMANN, M. D., of St. Louis.

Notwithstanding that from time to time great epidemics of yellow fever have visited this continent, in our part of the country it has fortunately been always so rare that quite a number of physicians, perhaps the majority of them, have never had an opportunity for personal observation. During this year, however, through a coincidence of circumstances, the early outbreak, the violent character of the plague, and the extensive communication with the South by rail and river, a larger number of sporadic cases has been imported to St. Louis than perhaps ever before. The erection of quarantine against the infected districts, connected with a hospital for the reception of the sick taken from the boats and picked up in town, furnish some valuable material for observations on the disease in all its different stages.

Acting as physician under that institution, and, as such, being among the small number to whom this opportunity was confined, I should not think it proper to withhold from the profession the results of some of these observations, although they may lack perfection in more than one point, owing to some very material difficulties. I trust to the sound judgment of our profession in scientific matters, that no one will expect any new theories as to the cause, character or treatment of yellow fever from a fortnight's experience on a small number of cases, but simply a contribution of the facts observed.

In the following, I give the history of five typical cases terminating fatally and one case of recovery, all coming from the South, two by railroad, four by boats.

Chas. N——, æt. 26, admitted September 8th. Says he did not feel well for the last ten days, but on the 3rd inst. took sick with fever; had pains in the lumbar region. At present he only complains of tenderness in the stomach, but does not vomit; tongue coated in the middle, borders red; eyes slightly injected and a little yellow; temp., 100.9°; pulse, 92. A dose of calomel

and oil ricini were ordered, and afterwards 10 gtt. of tincture digitalis and 5 grs. iodide of potassium every two hours.

7TH, A. M.—Temp., 99.2°; pulse, 84. Had two stools during the night, and passed a quantity of light orange-colored urine containing much albumen. Had frequent vomiting of limpid fluid. Medicine and extract of beef only given by enema. Mustard plaster on the epigastrium, and repeated foot baths.

7TH, P. M.—Temp., 101°; pulse, 120; patient very restless, delirious, later in the evening, raving at intervals; had to be held in bed. About 10:30 P. M., subcutaneous injection of morph. sulph. $\frac{1}{6}$ gr. Quiet thereafter, pulse remaining the same during the night; respiration very quick; temperature decreasing.

Patient died on the morning of the 8th inst., in profuse perspiration, the sixth day of his sickness.

W. I. W——, æt. 26 years, left Memphis, September 4th. While on the train, about six hours before his arrival in town, he was suddenly seized with chills, fever, pains in his forehead and back. On the morning of the 5th he called for medicine at the Dispensary and was sent to the Hospital. Patient exhibits a high degree of prostration; his gait is unsteady and slow, and when roused from his drowsy sleep answers questions with apathy and indifference. Conjunctivæ much injected and distinctly yellow, which, together with a vacant glare of his flushed face, gives him a peculiar aspect. Tongue coated dirty brown; great tenderness in the epigastric region. Urine contained albumen. Temp., 104°; pulse, 96 to 100. During the next two days frequent vomiting; all symptoms aggravated except temperature and pulse, which are reduced to 102.5° and 64 on the morning on the 8th, when the first signs of black vomit appeared. Towards the evening the temperature rose steadily, and reached 105° at midnight. Applications of cold sheets brought it down, but did not awake the patient from a deep stupor, in which he died the next morning, the fifth day of his illness.

P. M——, æt. 35 years, admitted September 13th, fell sick on the 9th with chills, little fever, pains in head and back, frequent vomiting and great weakness. Temp., 100°; pulse, 60 to 64. On examination nothing abnormal except some tenderness around the umbilical region. No injection and coloring of the eyes. While being examined he suddenly complains of pains in his legs, and soon after vomits a liquid looking brown from

numerous dark membrane-like particles suspended in it. Calomel and oil ricini.

14TH, A. M.—Had one passage during the night of gray color, but no urine. Has still some pain in the lumbar region; vomits everything he takes. Temp., 100°; pulse, 68. In the afternoon a catheter was introduced and about an ounce of light orange-colored urine obtained, which contains a large quantity of albumen. Temp., 100°; pulse, 60; respiration, 24. During the night patient is wrapped up in hot wet blankets. Champagne given freely, and jaborandi gtt. every two hours, injected subcutaneously. The same drug was administered the next day in combination with digitalis and iodide of potassi by mouth, the vomiting having ceased entirely.

15TH, A. M.—Warm hip baths are added to the treatment. Towards evening patient is very restless and delirious; extremities cold, skin moist. At 8 P. M., temp., 105°; pulse, 100; easily compressible; respiration between 40-50. Dies in profuse perspiration between 9 and 10 o'clock, the seventh day of his sickness.

C. H. F——, æt. 25 years, admitted September 15th from a boat. Sick since the morning; one chill; pains in the supraorbital, but particularly in the lumbar region. Tongue slightly coated; nothing peculiar on examination. Temp., 101.5°; pulse, 88. Ordered calomel and oil ricini.

16TH, A. M.—Patient slept well; did not complain about any pain; had several passages during the night and voided some urine, which does not contain the least sign of albumen. Temp., 102°; pulse, 88; tongue little more coated than the day before. Patient was considered out of danger; no medicine given but was advised to keep quiet and to take nothing but a little milk and lime water. At 10 o'clock, however, he began to grow worse. The pains in the forehead and across his back returned more vehemently; coughing and deep respiration caused pain; the stomach and the tongue were thickly coated. P. M.—Temp., 104.5°; pulse, 92. Three doses of 10 grs. of quinine were given; the last one he vomited.

17TH A. M.—Temp., 104°; pulse, 80; patient was restless; tenderness around the umbilicus; no vomiting; urine a little turbid, containing much albumen. Quinine in emulsion with subnitrite of bismuth, 40 grains in a two ounce mixture, a teaspoonful

every hour. 6 P. M.—Temp., 104¾°; pulse, 76. At 7 o'clock P. M., an hour after he had taken the second dose, patient vomited a limpid fluid, specked with blood.

18TH, A. M.—Temp., 102.5°; pulse, 76; felt easier and slept much better than he did the night before; vomited twice, the liquid being mixed with dark flakes; complains of tenderness over the stomach and a feeling of pressure over the lower part of the abdomen; had one operation and passed water during the night. P. M.—Has not vomited during the day; is quiet, sleeping most of the time.

19TH, A. M.—Temp., 102°; pulse, 96; had black vomit several times during the night; became unconscious towards the morning and died before noon, the fifth day from the beginning.

W. B——, aged 28; admitted Sept. 15th; taken from the same boat as Case IV. Sick since the 13th with chills and fever; pains in the forehead and back; vomited after taking a dose of mustard; face red, flushed; eyes much injected; tongue coated; pain at first only in the left hypochondrium, in the evening over the whole epigastrium; temp., 102.5; pulse, 92; ordered quinine, five grs. every hour.

16TH, A. M.—Temp., 103.2°; pulse, 76–80; respiration, 24; several passages during the night; vomited frequently a limpid matter; no head ague, only slight pains in the lumbar region; tenderness of the epigastrium unchanged; one particularly sore spot in the lower border of the liver; dullness, corresponding with the seat of the gall bladder or pylorus; urine passed freely, of a light yellow color; some reaction; copious deposit of reddish white, scaly sediment; contains albumen. P. M.—Temp., 103.3°; pulse, 80; increased pain in the back and stomach.

17TH, A. M.—Patient very restless during the night; several passages of gray color; frequent vomiting, the discharged fluid mixed with brown flakes and red particles of coagulated blood; eyes more injected; increased tenderness of stomach; great prostration; face pale and somewhat yellow; temp., 103°; pulse, 80. P. M.—Temperature and pulse the same; frequent vomiting of black matter; hemorrhage of the nose and constant hiccup, which resists all efforts at relief. Dies the next day before noon; conscious a few hours before his death, the sixth day of his sickness.

W. B——, aged 21 years; admitted September 7th; came

from Memphis three weeks ago, on the Iron Mountain Railway; has not been well since August 31st; dates his present illness from the 1st, when it began with pains in the forehead, stomach and back; at present, great tenderness in the epigastric region; dullness and enlargement of liver; eyes injected and slightly yellow; tongue, thickly coated; slight pains in the forehead; great prostration and drowsiness; no albumen in urine; vomited three times to-day, the last time mixed with a few particles of blood; bowels, constipated; temp., 101.9°; pulse 80. Took one dose of calomel, and quinine afterwards. P. M.—Temp., 100°; pulse, 92.

8TH, A. M.—Temp, 104°; pulse, 100; frequent vomiting, but without blood. P. M.—Temp., 105°; pulse, 116; urine contains albumen and coloring matter of bile. One dram of quinine was given by injection, and cold sheets applied for an hour.

9TH, A. M.—Temp., 102.5°; pulse, 92. The next morning the temperature is reduced to 99°; pulse, 92; temperature rising again, and towards night reaching 105°; pulse, 100; treatment same as the night before—cold sheets and injection of one dram of quinine.

10TH, A. M.—Temp., 99°; pulse, 92; quinine continued; less albumen in urine.

11TH, A. M.—Temp., 100°; pulse, 84. The next day urine is free from albumen, and convalescence begins.

Besides these cases related above, the writer has seen a number of others which did not differ in any material point. In order to obtain a correct idea about a disease, it is of less importance to take a flying survey over a large number of patients than to find out by careful examination of the single cases the constant and invariable symptoms which, taken separately, may be found in other diseases also, but taken in combination will form a well-defined and characteristic type. Yellow fever makes no exception to this rule, and it was the conformity of some symptoms which probably led to the theory that yellow fever and malaria contagium were identical—which is still maintained by a few physicians in the face of contradictory facts. There may exist a relationship between all the microscopical organisms (bacteria, etc.), which have been discovered in the blood and discharges in most of the infectious diseases, and are supposed to be their generators, but unless we know more of their chemical and physical qualities and the part they play in

the pathological drama, we are referred to the microscopical phenomena for theories on causes and effects. And here from the well known fact that one contagious disease never changes to another, no other inference can logically be drawn but that a specific effect must have a specific cause. Malaria has never been known to assume the character of yellow fever even in such districts where it is endemic in its most pernicious and intense shape. This ought to be a sufficient proof of non-identity, for identity could only be concluded from the transformation of one type into the other, such as actually takes place in malarial diseases.

SYMPTOMS.—We will now examine each symptom in regard to its diagnostic value. The supraorbital pain presents nothing peculiar, while the pain in the back is frequently found in malaria also, but seldom so distinctly confined to the locality of the kidneys, which is not absent in a single case. Vomiting and tenderness of the stomach offer nothing characteristic, and even the discharge of red or decomposed blood, known as black vomit, may occur in cases of ulcers, cancers or in mechanical or chemical injuries of the stomach. But as it will always be easy to ascertain by exclusion the true cause of these symptoms, they are of great importance to the diagnosis.

The course of the fever is very singular. It is distinguished by a remission within the first three to five days. There is a striking misproportion between the temperature and the pulse. Altogether the temperature is not very high, seldom exceeding 104° F., (40C.), and reaching 105° F. (40.55C.) in only two of the cases. The remission is obvious in cases II and IV. These two cases were observed from the first beginning, while the others had been sick for several days before they were admitted. In both of these the temperature fell from 104° to 102° F. (38.58C.) within the first four days, in the first one rising again and reaching 105° F.; this occurred about twelve hours before death; in the latter case the temperature remained at a low figure to the end.

Not less characteristic is the pulse, its figures being quite inadequate to the height of the temperature. A pulse of 120 was counted once only in Case I, while the temperature was low; in this case there were grave cerebral symptoms. At 105° the highest numbers of the pulse were 116, and two times at 100°; at 104° the pulse raised from 80 to 100; at 102° and 103° it was as

low as 72; at 99° to 101° it was as low as 60, and in another (a fatal case not recorded here) it was even below 60. From the fact that the same misproportion between the pulse and the temperature existed in every case that came under my observation, without a single exception, I consider it as one of the most valuable diagnostic symptoms. That so little attention has been paid to this circumstance heretofore, even in the latest medical works, the writer is inclined to attribute to neglect in the use of the thermometer, which, as a diagnostic expedient, is still far from being universally adopted.

Hyperæmia of the conjunctivæ and a yellow color of the skin are not in themselves pathognomonic, for the former will be found in congestion of the brain and the latter in jaundice in a still darker color, but in connection with the other symptoms they will add to the confirmation of the diagnosis.

Albumen was found in the urine in all severe cases, as was bile pigment in most of them. The color of the urine seems to be of importance as a diagnostic character, because, as far as I could see, it was never of that dark brown tinge so commonly found in malaria; even the small quantity obtained by means of a catheter in Case III was only of a light orange color. Examination of the spleen will be of no avail for diagnosis, as in our country, the enlargement of this organ, as a consequence from malaria, exists in a large percentage of the population, while, on the other hand, it may be absent in the most pernicious forms of the disease.

There is one symptom deserving of notice which, although not always present, is peculiar to yellow fever exclusively; it is an offensive, carcass-like odor exhaled from the patient. This was distinctly perceptible in several cases.

Whenever all or the most conspicuous symptoms are present, no difficulty in making a precise diagnosis ought to exist. It seems strange that in some places there could be a difference of opinion among physicians as to the nature of the disease, after several patients had succumbed, and doubtlessly shown some pathognomonic features. Quite different, however, are the light cases, which are analogous to abortive typhoid, or to cholera diarrhœa, which can only be recognized as such by the presence of an epidemic. The rapid abatement of all symptoms after a short duration, and the non-appearance of malarial attacks afterwards, without the use of quinine, may be useful to distinguish it

from malarial fever. The duration of the disease is naturally variable, depending upon the intensity of infection, and upon the individual power of resistance, which may be increased or diminished by outer agencies, as climatic influence, prophylactic treatment, etc. In my cases, a little over five days was the average time elapsing from the first chill until the fatal end; the extreme of duration being one death on the second day and one death on the twelfth.

As the immediate cause of death, we can distinguish a general and a local effect of the yellow fever poison. To the first belong all the conspicuous symptoms—the fever, the yellow coloring of the integument, the hyperæmia and hemorrhages of the mucous membranes—which indicate a morbid alteration of the blood and insufficient nutrition of the vital organs. Death may occur very early in the outbreak of the fever, or the patient may enter the second stage of remission, after which the temperature sometimes rises again, as in Case II, or it may remain low, as in Case IV. The most protracted case was that of a powerful negro who was admitted on August 31st and died on September 11th. During the last four or five days of his illness he was constantly vomiting large quantities of black matter; his extremities were cold, his pulse-beat from 54 to 60, yet remaining conscious to the last.

In cases of the second order, the general symptoms are less remarkable, or they may be absent, except some pain and a slight fever at the beginning. These patients usually die from retention of urine under the form of uræmic intoxication, as the history of P. M——, (Case IV) shows. The fatal termination in the first case I can only attribute to a local effect of the contagium upon the brain, as neither high fever, black vomit nor retention of the urine were present. It is hardly necessary to remark that these two types are not always distinctly separated, but various intermediate forms may be found which alter the pathological picture considerably.

Concerning the treatment, the same principles adopted for all acute infectious diseases will apply to yellow fever also. We do not know any remedy to destroy the poison within the system, and, therefore, all our therapeutic efforts must be so aimed as to place the patients under favorable conditions to overcome the attack, and to counteract its deleterious effect as much as possible. Unfortunately, in yellow fever, success will not re-

ward our exertions in an equal measure with that of typhoid fever; for instance, where the danger principally lies in the secondary consequences of a continued high fever, which can be removed to some extent by reducing the temperature through the application of cold water, and the use of quinine. Statistical tables, running up to many hundreds, show the satisfactory result of this treatment in indisputable figures by a decrease of the mortality from 30 to 26 per cent. down to from 8 to 4 per cent. In yellow fever, however, it is less the influence of a long, lasting fever heat that must be feared than the intense decomposing effect of the poison upon the blood, and the subsequent acute degeneration of the vital organs, particularly of the stomach, heart, liver and kidneys, which, on post mortem examinations, are continually found in a morbid condition.

In the Quarantine Hospital, the patients were given a dose of calomel and castor oil if their bowels were constipated at admittance, as was usually the case; afterwards digitalis and iodide of potassium were prescribed. This latter remedy was recommended by a prominent physician, as a diuretic, in order to prevent retention of urine, but I never could see the least beneficial effect from its use. When the fever rose up to 104° or above, wrappings of cold sheets were made, and quinine given per os or per anum, with a view to the reduction of the temperature, which was promptly effected. To expect more from this treatment or to recommend the hydropathic method as a specificum against the contagium, as has been done in the South during the present epidemic, only shows great ignorance of its advocates.

Crushed ice and champagne were almost the only refreshments that the irritable state of the stomach would allow; enema of extract of beef and whisky were given, but with no marked success.

None of the patients in whom the pathognomonic symptoms: black vomit, yellow color or retention of urine were well marked, recovered; and it seems that the pathological changes upon which they depend are incompatible with the preservation of life. As the statistical figures of mortality in every epidemic show, our therapeutical means are insufficient against a certain degree of infection, but there may be a point in some of the cases at which proper treatment will turn the scale in favor of recovery in the same way as the antipyretic and stimulating

method undoubtedly does in typhoid fever. This is proved by the comparative results expressed in figures. The same test must be applied to different plans of treatment in yellow fever. There may be a few sporadic cases of recovery in which some favorite drug of the attending physician, as for instance, aconite, digitalis, gelseminum, iodide of potass., or nox vomica have been employed with a view to perform some certain task in the human system to control the nervous system, the brain, the kidneys, etc., but this cannot be considered as reliable proof of the superior effect of either remedy. We must remember that less than half a century ago, pneumonia was treated with repeated venesections; water and food were withheld in typhoid fever, and when a patient recovered in spite of this treatment, it was ascribed to its beneficial effect. By observing the natural unaltered course of these two diseases, a measure was obtained for the relative merits of therapeutical interferences, and a basis was found upon which a rational plan of treatment could be established. Until we possess similar reliable facts in regard to yellow fever, the therapie must be rather intended to prevent injury than to effect a cure.

At three post mortem examinations, the liver was in a state of fatty dengeneration; the kidneys semmed to be in similar condition, the corticle portion yellow-brown and friable, the pyramids dark brown, with distinct longitudinal white streaks, and numerous ecchymoses in the capsule; heart soft, pale, somewhat yellow and friable; mucous membrane of the stomach in a state of acute inflammation with numerous ecchymoses; its contents consisting of a more or less black, tar-like fluid and a slate-colored mucus; blood, fluid, with few or no coagula; spleen variable, in two cases enlarged with an ink black pulp imbedded in unusually strong fibrous meshes; in one case, (a girl of fourteen) of chocolate color and very friable.

Article IV.

Removal of a Tumor Involving the Entire Partotid Gland.

By Jno. T. Hodgen, M. D., of St. Louis.

Peter H. Berg, of Salina, Kansas, æt 61; first observed a tumor in front of the right ear twenty years ago. The tumor remained about the size of the end of his thumb until the winter of 1877–78, when it increased in size. In June, 1878, he observed that the right eye could not be closed. In September following, he noticed that the mouth began to be drawn to the opposite side.

About the 1st of November, 1878, he presented himself with a marked though not complete paralysis of all the muscles supplied by the anterior branches of the portia dura, and a tumor the size of a small henegg.

Nov. 9th.—Assisted by Drs. McDowell, Mudd, Boutwell, and Mr. Dewey, and in the presence of a number of medical students I operated. The patient was put under the influence of ether by Dr. Boutwell. The face was turned well to the left side, and the chin elevated. An incision beginning an inch and a half below the tumor, at the inner border of the sterno-cleido mastoid muscle was extended along that border of the muscle until the mastoid process was reached; it was then directed forward below the lobe of the ear, and terminated below the zygoma, near the point of junction of the temporal and malar bones. The lower end of this incision was deepened along the anterior border of the sterno-cleido mastoid muscle until the sheath of the carotid artery and jugular vein was reached. Dr. McDowell now introduced his finger into this cut so as to control the carotid artery if required. A careful dissection was now made removing the skin from the surface of the tumor, and turning the flap forward the anterior border was reached, the duct of Steno and the transverse facial artery were cut. Keeping close to the tumor the front portion was detached as deep as the deeper part of the ramus of the lower jaw. The posterior part of the tumor was in the same way separated from the anterior part of the sterno-cleido mastoid muscle; also the upper part down to the auditory process of the temporal bone. The dissection of the lower

part was deferred to the last, so that if bleeding should require it, the remaining portion of the tumor could be detached rapidly, thus making room for the ligation of the vessels. To this point only two or three little vessels required ligatures. Drawing the tumor from below and keeping close to it—tearing mostly—only using the knife to cut the more resisting tissues, the deeper portion, including the external carotid artery and principal trunk of the portia dura was reached.

The tumor was now so far enucleated as to leave only the apex intact passing deep and near the styloid process of the temporal bone. In removing this, the external carotid artery was cut. Dr. McDowell stopped the blood through the common carotid and there was little hemorrhage. The tumor was quickly torn out, and the carotid was seized with the forceps and tied without difficulty. It was now found that the temporal and internal maxillary arteries had been severed and gave a little blood; both were tied. A careful examination of the wound was made by Drs. McDowell, Mudd, Boutwell and myself, and it was concluded that all the gland had been involved in the disease, and all removed except a small part at the upper portion near the auditory process. This little portion, though appearing healthy, was removed. There was but little oozing, and this soon ceased. The wound was washed with a twenty grain solution of chloride of zinc. The flap was laid back, and a compress of cotton wool applied over a cerate cloth, and all held in position by a bandage. Very soon after the operation, the right side of the face, the right conjunctiva and the side of the neck were intensely red; saliva flowed freely, so much so as to constantly dribble from the mouth. Three hours after the operation, the whole right side of the head, face and neck, were œdematous to a marked degree. This œdema had mostly disappeared at the end of the twenty-four hours, together with the redness. The condition of the pupil was not observed.

Some days later the patient had a slight erysipelatous inflamtion beginning at the wound and extending to the head and face. Pus formed under the flap, requiring evacuation by the knife. In all other respects, the patient progressed well. The last ligature was removed November 27th, 1878, and the patient left for his home November 29th. All the muscles on the right side of the face were paralyzed, including the anterior belly of the occipito frontalis and the corrugator supercilii.

Reports on the Recent Progress of Medicine.

Article V.

SURGERY.

By H. H. Mudd, M. D.

Recently Mr. Jonathan Hutchinson and Mr. Thomas Bryant, of England, have made valuable contributions to the surgical treatment of intestinal obstructions. The memoranda for diagnosis and treatment given by Mr. Hutchinson will be found in the Periscope of this journal under Surgery for December, and should be carefully considered, as they are the result of large experience, and of conscientious and careful observation.

In the paper by Thomas Bryant is given a table of cases of intestinal obstructions obtained from Guy Hospital reports, which I suppose exhibits fairly the relative frequency of the different varieties of obstructions excluding those of hernia: Acute abstructions, 33; chronic obstructions, 76; intussusceptions, 15. Total, 124. This makes a very important clinical classification into acute and chronic cases. The intussusceptions may occur in either class, and the chronic obstructioms will sometimes assume acute conditions, but this does not invalidate the clinical importance of the two divisions. Considering first the larger class, viz., chronic obstructions, we find that of these three were the result of mechanical pressure of tumors, and three of fæcal impaction. These may be dismissed from further consideration for they demand only the mechanical removal of the impaction by rectal manipulation—oily enemata, etc., or right or left lumbar colotomy. The indications usually being clear while the cases are relatively infrequent. We may, then, divide the remaining seventy cases into two classes, viz.: 47 from stricture (2 small intestines, 45 large intestines), 23 from matting together of intestinal coils, from peritoneal and cancerous disease.

If, then, we see a patient suffering from abdominal distension, nausea, borborygmus and other symptoms of marked intestinal

obstructions, and find that he has previously suffered from difficulty in obtaining movements from the bowels, or in the act of defecation accompanied with occasional discharges of mucus or blood or change in form and character of the stools, we may at once assume that the acute symptoms are engrafted on a chronic condition and refer it to either a stricture or obstruction from peritoneal adhesions. Designating by "contraction" the obstructions which occur almost uniformly in the small intestines as a result of inflammatory, or cancerous or peritoneal disease, and by "stricture," the narrowing which is the result of disease of the bowel.

Now the diagnosis between these two forms of obstructions is according to Mr. Bryant a comparatively easy matter. If digital examination of the rectum, manual explorations of sigmoid flexure by introduction of the hand into the rectum, or the examination of the region of the ascending or descending colon, fail to locate with precision the more frequent form of obstruction, viz., stricture, then we shall find that the facts gleaned from "the light of pathological knowledge speak with no uncertain sound," for in the case of contraction, the symptoms are referable to a difficulty in the passage downward of the intestinal contents as evidenced by occasional attacks of griping colicky, abdominal pain and irregular, incomplete and uncertain incestinal evacuations which, when they do occur, are painless and healthy. In this condition the patient may feel perfectly well between the attacks.

In stricture there is a very gradual progress toward a complete obstruction. The distension slowly increasing with an imperfect and partial disappearance after copious evacuation, very different from the perfect ease and comfort which follows relief from an attack of colic dependent on congenital diverticulum or contraction caused by band of adhesion. The pain is due to distension, which is apt to be lumbar and epigastric, and is accompanied by painful defecation. Now add to these indications the fact that stricture is to be looked for in advanced life, each year added to the decline increasing the probability of its occurrence, and we have a comparatively clear field for a diagnosis and for treatment. When the obstruction from stricture has reached a point where it threatens life, we should not increase the danger by useless aperients or enemata, nor conceal its dangers by opium, but perform at once right or left lumbar colotomy. When con-

traction is the source of trouble, and laxatives fail to relieve, enterotomy in right or left iliac fossa should be performed, if from uncertainity of site and character of the obstructions, laparotomy is set aside as injudicious.

Turning now to our table we find that of the cases of acute obstruction, numbering 33, 1 is from internal hernia, 7 from twists or volvulus, and 25 from bands, formed by lymph diverticula, appendix caeci adhesions to neck of hernial sac or to the attachment of tumors.) Acute strangulation of the bowel, whether from internal obstruction or from hernial protrusion, is definite and sudden in its origin, accompanied by severe central pain, sickness and collapse, constipation, inability to pass wind, visible coils of distended intestines, and possibly scanty or suppressed urine. We can readily diagnose the presence of strangulated bowel, but can not so easily determine the source of the obstruction. Mr. Hutchinson says, in reference to treatment, abstain from food and medicine, using large enemata in the inverted position of the body; resort at once to anæsthetics, and make a thorough examination of abdomen, and test thoroughly and repeatedly in uncertain cases the efficiency of abdominal taxis, avoiding exploratory operations where the cause of obstruction is not diagnosed, reserving laparotomy for cases where diagnosis of invagination is clear. On the other hand, Mr. Bryant states that the inevitable tendency of unrelieved strangulations is toward death, and that relief of internal strangulations from natural influences is not more likely than it is in strangulated hernia, where the only efficient and justifiable means of relief is herniotomy, and further states that no prudent surgeon should leave a case of internal strangulation to run its course without laparotomy. The recoveries after laparotomy have been few, but I suspect it is because the operation has been practiced only as a *dernier ressort* after manipulation has injured the part, and inflammation has been established. All surgeons know how disastrous is much manipulation of a hernial protrusion, and how fatal the operation where it has been postponed until the last minute. The fatality attending such cases is very uniform, and laparotomy will not be less so when resorted to at the last minute. I hope and believe the operation will give better results where it is performed before irreparable injury has been inflicted on the tissues.

Intussusceptions may be either acute or chronic. They are of

three varieties rectal, ilio-colic and iliac, and are far more frequent in children than in adults. Where the invaginated portion is simply incarcerated it may give rise to slight disturbance, but where it is strangulated its symptoms are marked. The pain is local but not fixed in its position, as it is in band or contraction. It is frequently relieved by pressure, and is associated with tenesmus and bloody mucoid stools. There is frequent absence of abdominal distension. These cases not inrequently correct themselves, and in acute cases we may ordinarily wait a few hours, using meanwhile inflation, inversion of body, abdominal manipulation, opium and anæsthetics, while in the chronic, pursuing the same course, we may generally wait a week or more, and then, the diagnosis being clear, perform laparotomy, for the tendency of such cases where not soon relieved by natural or operative measures is toward death.

Realizing how difficult it is to make the diagnosis in cases of intestinal obstruction, we append a table offered by Mr. Bryant:

(See page 35.)

J. B. Roberts, M. D., of Philadelphia, has distributed a reprint from the *Edinburgh Medical Journal*, on "Refractures for the Relief of Deformity following Badly Treated Fractures of the Extremities," in which he endeavors to indicate the province and methods for the operation. Impairment of function, is, he thinks, the prime indications for refracture, and when this exists, one would infer from his article that no other obstacle would deter him from the undertaking. He admits that those cases in which angular displacement is the deformity, are the most favorable for remedial means, but claims that overlapping, where it impairs function, is readily relieved, and where from proximity to a joint its movements are limited by thickening at the site of fracture, or if in fracture of the bones of forearm rotation is imperfect, he refractures. Indeed the only limit he admits is the ability of the surgeon to refracture, and this he thinks hardly has any limit in time, for he says, the period required to give the bond of union the solidity of the original bone, if indeed that ever occurs, must be looked upon as indefinitely long. Violence to accomplish refracture should be applied at site of the fracture, and if the overlapping is lateral it should be antero-posterior in direction or if the overlapping is antero-posterior the force should be lateral. He claims that there is but little danger in fractur-

A HELP TO DIAGNOSIS IN CASES OF ABDOMINAL OBSTRUCTION.

—	ACUTE— Obstruction or Strangulation.	CHRONIC OBSTRUCTION— From Disease of Large Intestine.	CHRONIC OBSTRUCTION— From Disease of Small Intestine.	ACUTE OR CHRONIC— Intussusception.
Previous condition of subject.	In good health.	Ailing for some time with abdominal symptoms.	Ailing, with previous attacks of incomplete obstruction.	In good health.
Mode of Attack	Very sudden and acute.	Symptoms gradually increasing in severity, or acute grafted upon old.	Paroxysms of colicky pain, upon old symptoms.	Sudden onset, and increasing when acute, subsiding when chronic.
Early symptoms:				
Pain	*Abdominal pain*—fixed, central, and paroxysmal.	*Pain* diffused and increasing with distension,	*Pain*—paroxysmal, with intervals of ease and hypogastric pain.	*Pain* fixed, and often relieved by pressure.
Vomiting	*Vomiting* rapidly becoming fæcal.	Intermittent and fæcal towards the last.	Occasional during attack of	Rapidly becoming fæcal in acute cases, absent or intermittent in chronic.
Collapse	*Collapse* very marked.	Absent till the end.	Absent till late.	Very marked in acute cases, not so in chronic.
Constipation	Absolute constipation and inability to pass flatus.	Gradually increasing in severity.	Attacks of constipation, alternating with natural relief.	Occasionally present, but, as a rule, "dysenteric" symptoms, straining, tenesmus, muco-sanguineous stools, or hæmmorrhage.
Abdominal Distension	Rapid and severe, central and hypogastric.	Gradually increasing, lumbar and epigastric.	Never great, increased during attack.	Rarely severe.
Manipular Indications	Tympanitic; distended coils at times to be felt.	A fixed swelling at times to be felt in either iliac fossa.	A doughy condition of bowel, becoming knotty during attack.	Distinct tumor often to be felt, its shape varying during attack.
Visible Indications	Abdomen tense in umbilical and hypogastric regions, with visibly distended coils.	Abdomen broadly distended; coils of intestine visible.	Coils of intestine very visible.	Nothing marked to be seen.
Peristalsis	Rarely visible.	Marked.	Very marked.	Not visible.
Urine	Scanty or suppressed.	Natural in quantity.	Natural.	Natural.
Rectal Examination	Lower bowel probably quite empty.	Stricture of the bowel may be felt in rectum or in sigmoid flexure by manual examination.	Nothing abnormal.	Rectum may contain mucus or invaginated bowel.

ing, except at original break, and thinks there is none from pyæmia, laceration of the vessels or non-union. He cites eight or nine cases occurring in the practice of various surgeons as evidence of the propriety of his position, and in formulating his conclusion, says "Refracture is the method of correcting deformity after maltreated fractures, because it gives relief without suppuration, which is liable to follow drilling, and almost certain to result from the operation of excision." Now turning to his table of cases reported, we find that six out of nine were subjected to refracture within six weeks of the time of the orignal injury. The other three cases were respectively of ten, fifteen and twenty-nine weeks duration, and it is very possible that any one of the nine cases may have been soft enough to have been molded by gradual pressure and extension into proper position, and certainly it is entirely within the limits of probability to assume that this was the fact in those cases that were refractured within six weeks.

CASE IV.—A boy, aged 15 years; had fracture of the middle third of the femur, with shortening of one and a-fourth inches, for which the operation of refracture was performed at the end of three and a-half weeks. Dressings were then applied to prevent overlapping. Twelve days after the operation an immovable plaster of Paris dressing was applied to the leg from the waist to the ankle, without etherizing the patient." "In about three weeks the plaster dressing was removed, revealing a shortening of fully one inch, whence it was decided to apply extension by means of weights and adhesive strips." "After using extension for ten or twelve days, six and one-half weeks having elapsed since the fracture, the union seemed to be firm and there was but half an inch of shortening. "Observe now that the history of the case claims firm union in the femur at the end of three and a-half weeks, and yet, nothwithstanding the well-known fact that refractures unite more rapidly than original ones, he at the end of four and a-half weeks after the refracture, finds the deformity almost as great as it was at the time of refracture, but gains in ten days by simple extension one-half an inch in length, this being a better result than he had from refracture and good evidence that it did not need to be refractured in the first place, but needed only the care which all surgeons should give to their fractures at the time the callus is hardening,

viz: care to correct deformity and insure union of fragments in good position. The treatment given these nine cases may have been just what they needed, but it must be remembered that, although none of them were treated by the author, he offers them as evidence of the propriety of the position he assumes as an advocate for refracture.

The time here allowed to lapse does not invalidate the position of Hamilton, when he, as our author says, "thinks there is little hope of gaining anything in length, in cases of shortening caused by over-riding, because the muscles have become permanently contracted by adjusting themselves to the new condition of things."

Nor does the seeming absence of danger in these cases invalidate, in any particular, the objections entertained against the operation, for no surgeon would anticipate any danger of fracture except at site of original break, where it had so recently occurred; but it would be possible and probable after a lapse of two or three years. In the same condition, laceration of vessels would be possible, and inability to restore full length of limb improbable, when sufficient time had elapsed to establish the nutritive changes in the shortened muscles.

In conclusion, I think we may safely say that the Doctor's deductions are not so well established as to alter the status of the operation. Nor has he offered any evidence that the objections usually entertained by surgeons are not well grounded and proper. The operation is an important one, is proper in certain cases, but its danger and difficulties are to be found in older fractures than those quoted by the author. I think the great majority of fractures may be molded by pressure and extension when treated within three or six weeks of original break, and that refracture, when necessary within these limits, is readily accomplished and comparatively free from danger. Refracture, however, will not generally be necessary until a later period.

The pure rubber bandage of Dr. Martin seems to be gaining favor in the treatment of varicose veins and for ulcers not specific in their character. Mr. George W. Callender, of St. Bartholomew's Hospital, reiterates the importance of the specific directions given by Dr. Martin concerning the character of the bandage and its application. The bandage is to be applied during the day, and removed after retiring at night, the ulcer pro-

tected by some non-irritating oil or unguent at night. The bandage should be cleaned and dried, and applied before rising, but after the leg has been perfectly cleansed of all oil or grease. If the skin becomes irritated or the moisture of the skin is excessive, apply under the rubber a light bandage as a protective and absorbent. So far, I have not seen any reports confirmatory of Dr. Martin's good results from its use in diseases of the joints, but I believe such reports will ultimately support the Doctor's recommendations. Where it is applicable it certainly offers a better prospect of controlling inflammations and growths than does the more dangerous and less reasonable procedure of ligation of arteries.

Article VI.

DISEASES OF THE NERVOUS SYSTEM.

By C. H. Hughes, M. D.

1. Absence of the Corpus Callosum in the Human Brain—Dr. Eichler—*Archiv. für Psychiatrie.* Dr. R. Adriano—*Brain.*
2. The Pulsations of the Brain—Dr. Carlo Giacomini—Academia di Medicina di Torino dal Socio.
3. Pathological Lesions *vs.* Motor Centers—Dr. Maragliano.
4. Tumor of the Brain tending to confirm the views of Ferrier.—Prof. Watson, Manchester, England.
5. Traumatic Lesion of the left Cerebral Hemisphere confirmatory of Broca's and Ferrier's views.
6. Congenital absence of left hand with corresponding brain atrophy—By Dr. W. R. Gowers, University College, London.
7. A study of 415 cases of Tetanus—Yandell in *Brain* for October.

1. The defective mental development of the vertebrate animals, from the bird downwards, has been attributed by Sanders and others to the absence of the corpus callosum; and the most varied functions have at various times, and without the least foundation, been ascribed to this part. "It is astounding," as Hitzig justly observes in his contribution to Ziemssen, "Atrophy of the Brain," that Lapeyronie, on the basis of very bad observations, was able to gain such partisans as Louis, Chaport, Lane-

crotte, and others, for his hypothesis that the corpus callosum was the seat of the soul; and especially are we surprised in the light of what follows.

We are indebted to Dr. J. C. Galton for bringing before the English-speaking portion of the profession in the pages of *Brain* for October, another instance discovered by Dr. Eichler, of the Pathological Institute at Keil, of this interesting anomaly having existed in man, as in the cases of Sanders and Malinverni, without psychical derangement.

It would seem that where the corpus callosum alone is lacking, intelligence is not wanting. It is only where other portions of the brain are conjointly deficient that epilepsy, mania, idiocy, co-exist, as in a case reported by Dr. Robert Adriano, Superintendent of the Asylum at Perugia in 1876, for the translation of which we are indebted to Dr. Wm. W. Ireland in book notices of *Brain* for October. In Malinverni's remarkable case the septum lucidum was wanting, though the patient was mentally sound and died of an intercurrent disease.

"Dr. Adriano's case was a shoemaker 38 years of age, epileptic for twenty years and insane for seven years. His grandfather had been demented, and he himself was given to drunken habits. He had hallucination of hearing and touch, and finally restless dementia, and died of the consequences of epilepsia. Before being seized with this disorder the man could neither be called idiotic nor imbecile, though his intelligence was not good.

Not only the corpus callosum, but the septum lucidum and the middle and anterior part of the fornix, were found wanting. There was also a general softening of the brain, with œdema and paleness of the cortical substance, effusion of blood under the arachnoid, and inflammation of the middle part of the superior longitudinal sinus." The number of authenticated cases of congenital absence of the corpus callosum is very small. Dr. Adriano records his case as the twenty-second on record. References to the source of Sanders', Knox's, Turner's, as well as Eichler's cases, may be found on p. 419, Vol. I, No. 3, of *Brain*.

2. We are further indebted to Dr. W. W. Ireland and the pages of *Brain* for November, for the interesting observations of Dr. Giacomini made upon the brain of a woman whose left frontal bone at its posterior part to the extent of a five-franc piece was destroyed by syphilitic ostitis.

These observations, repeated during several months, were of inestimable value. Dr. Giacomini, assisted by Dr. Mosso, with the aid of Marey's cardiograph, placed the bottom of the instrument over the part of the brain laid bare, and elicited, by the curves and zigzags of the smoked paper, the rising and falling of the brain. The wave of the blood driven into the brain and distending all its vessels and volume was shown in the ascending curve, and the empty cerebral vessels and diminished volume of the brain were shown by the descending curve of the cardiograph.

One out of every three or four of the cerebral pulsations rose higher than the others, caused by the respiration.

At every inspiration the blood would flow more freely from the vessels of the brain, and the curve of the smoked paper would then descend the lowest. During respiration the blood returns with difficulty from the brain, hence an elevation in the curve of the cerebral pulsations.

A rotary cylinder applied to the chest indicated the movements of the thorax, and showed the exact correspondence of the respiration with the highest part of the cerebral curve, and of the inspiration with its descent.

The pulsations were greatly increased by compressing the jugular veins, and, *by sleep induced by chloral, were twice or three times the usual size.* There were also unexplainable irregular undulations in the curves.

On compressing the carotids the cerebral pulsations ceased, and the pulse trace became straight for a while; but in a little while the pulsation returned, owing to the blood supply finding its way into the vessels from the basilar artery through the circle of Willis. Compressing the jugulars rapidly increased the volume of the brain.

These experiments drive another nail into the coffin of the dead doctrine that the brain is *a plenum*, and indicate hydrate of chloral as the proper hypnotic where insomnia exists, conjoined with anæmia. It would have been more gratifying had the Doctor shown the condition of the cerebral vessels in bromide of potassium sleep, and the insomnia of quinia and alcoholic excitation, as well as their secondary somnolence.

Drs. Giacomini and Mosso presented to the Academy of Sciences of Paris, in January, 1877, a report of which appears in the *Bulletin de Therapeutique*, and in the *Chicago Journal of*

Mental and Nervous Disease for October, of that year, conclusions similar to those reported in this paper, together with a photograph of his case.

He is reported in the latter journal, p. 811, to have found, during profound sleep with snoring, that there was quite a pronounced increase in the height of the cerebral pulsations, the respiratory oscillations and undulations being much more marked. This is somewhat at variance with the statement of Hammond—Diseases of the Nervous System, p. 19; Sleep and Its Derangements, p. 317, 1869,—"that during sleep the amount of blood circulating in the cerebral vessels is much greater than during wakefulness."

The essential to the production of sleep, as we have long believed and practically regarded in cerebral therapeutics, is to secure quiescence of the cells of the psycho-motor centers.

In insomnia with cerebral anæmia and great exhaustion of the ideational and emotional centers, stimulating hypnotics, like chloral, opium or whisky, act well, while, in inability to sleep from over-excitation of these same centers with general or local cerebral hyperæmia, agents like the bromides act best alone or with some chloral.

Drs. Giacomini and Mosso's experiments show that during the occlusion of the femoral arteries the cerebral pulsations are acuter and higher, and that every movement of the body and all intellectual labor is reflected upon the brain, which undergoes a visible modification in its volume and in the form of its pulsations.

These discoveries add much to our knowledge of the movements of the brain, but not so much as Dr. Beaumont, many years ago, with his patient, Alexis St. Martin, contributed to our positive knowledge of the stomach and its digestive processes. For it must be borne in mind that the cranial cavity is naturally closed, and the cerebral blood supply is somewhat modified by cranial openings, subjecting the brain and its vessels to atmospheric pressure. They prove, however, that neither the *plenum* nor *a plenum* theory of sleep is wholly true.

3. (*a*) Dr. Maragliano in the *Rivista Sperimentale di Freniatria*, (anno iv., Fasciolo i.), as noticed and abstracted by Dr. W. W. Ireland, for the October number of *Brain*, from an observation of 97 cases from French, German, English and Italian

sources, considers that Hitzig and Ferrier's views are substantially the same.

Dr. Maragliano, contrary to the opinion of Charcot and Pitres, who, basing their deductions on 41 observations, concluded that derangement of the movement of the superior extremity corresponded with a lesion of the middle third of the ascending frontal gyrus, thinks that the motor centers of the arms cannot be thus limited, but that these centers must cover the two upper thirds of the entire motor zone, for he finds *paralysis and convulsions confined to the arms, corresponding with lesions, disseminated over this whole tract*, and gives the following conclusions:

1. Alterations in the cortex of the cerebrum may cause alterations in the motor functions of the body.

2. The motor functions are influenced exclusively from the frontal and parietal lobes.

3. Frontal are more frequent than parietal lesions of convolutions.

4. In the frontal lobe the faculty of influencing motor function is confined to the ascending frontal gyrus and to the posterior part of first, second and third frontal.

5. Of all the frontal convolutions, the ascending gyrus is the oftenist injured.

6. In the parietal lobe the faculty of influencing the motor functions resides especially in the ascending parietal (gyrus centralis posterior).

7. Lesions are found in the two ascending or median gyri equally.

8. In the motor derangements of the upper extremity, the lesion may be found in the two upper thirds of the motor zone.

9. Motor derangements of both limbs correspond to lesions in the two upper thirds of the two ascending or median gyri.

10. When pronounced disturbances of the muscles of the eye are associated with motor derangements of one or both limbs, he always found a lesion in the inferior third of the ascending frontal gyrus.

11. Motor derangements of the superior palpebral muscles seem to correspond with lesions of the inferior parietal gyri.

12. The phenomena of excitation, cramps, convulsions, and

other epileptiform attacks, correspond indistinctly to alterations in the ascending frontal and parietal convolutions, and to points immediately contiguous.

(*b*) In this connection the conclusions of Dr. Palmerini, drawn from the three cases of left cerebral softening affecting the ascending frontal or anterior marginal convolutions are quite *apropos*.

After discussing the present condition of opinion regarding the localization of function in the brain, Doctor Palmerini concludes as follows:

1. In the frontal ascending or marginal anterior convolution exist *psycho-motor centers* (Albertoni), which exert a manifest influence upon the voluntary movements of entire groups of muscles of the opposite side.

2. These centers correspond in man to the sites indicated by Hitzig, Ferrier and Albertoni.

3. Lesions of these points produce persistent, but incomplete paralysis, susceptible of marked exacerbation and diminution.

4. This particular form of progress of symptoms and the permanent, if incomplete, paralysis, particularly when preceded by exacerbation and diminution, are two clinical characters of the utmost importance.

5. The constancy of motor lesions consisting always in phenomena of paralysis and ataxy, shows that the nature of these centers is motor (*psycho-motor*) and not sensory. (From these clinical confirmations of Ferrier and Hitzig's researches it looks as though Dupuy, Braun, Burdon-Sanderson and others, who think that the motor phenomena following electrization of the cerebral cortex, is due solely to the transmission of electricity to the corpus striatum and medulla oblongata, and all others who deny the existence of motor localizations in the anterior and lateral convolutions of the brain, will have to gracefully surrender their views.)

4. Prof. Watson, of Owens College, Manchester, England, reports in *Brain*, for July, a case of tumor of the brain, involving the upper half of the ascending frontal and parietal convolutions, and the anterior half of the posterior parietal lobule, causing paralysis in the left leg and arm, and tending to confirm the conclusions of Ferrier.

The tumor measured three inches in diameter in all directions, extending to the floor of the right lateral ventricle; it had obliterated in its course a portion of the cerebral mass extending from the ascending limb of the sylvian fissure in front, to within an inch of the external parieto-occipital fissure, posteriorly.

5. Dr. W. Maccormac, F. R. C. S., and Surgeon to St. Thomas' Hospital, likewise presents in the same number of *Brain*, a case of traumatic lesion of the left hemisphere with right brachio-facial paralysis and aphasia, confirmatory of the conclusions of Broca, Sydney Jones, Simon, Proust, Terillon, Lucas, Championniére, Bastian, Ferrier and others, that lesion of the left hemisphere, in connection with failure of the power of speech and memory, is no mere accident.

6. Dr. W. R. Gowers, Asst. Prof. of Clinical Medicine, in University College, presented a case to the Royal Medical and Chirurgical Society, of London, which appears in Part III of *Brain*, of congenital absence of one hand and corresponding brain atrophy in the hand region of the opposite hemisphere, with the remark that the chief interest in the case arises from the fact that the diminution of the size of the ascending parietal convolution on the opposite side of the brain occupies precisely the area, stimulation of which, according to the experiments of Ferrier on monkeys, causes movement of the opposite hand.

7. Dr. David W. Yandell, in *Brain*, for October, finds from a study of 419 cases of tetanus, that 80 per cent. of them were males; 7 per cent. occurring in the first ten years of life, with 60 per cent. mortality; 20 per cent. occurring between 10 and 20 years, with a mortality of 38 per cent. The death rate could not be made out in the remaining decade, the cases being simply reported as adults; 15 cases occurred after 50 years, and one at 89 years.

Eighty-eight cases were from wound of the foot, and 90 from wound of hand; 28 of the upper extremities, exclusive of hand, and 67 of lower extremities, exclusive of foot. Wound of the head, 20; of the trunk, 4; cancer, 1; abrasion of the cornea, 1; abortion, 10.

Neither the situation nor character of the injury influenced the result. Death followed in 40 per cent. from hand wounds,

and in 44 per cent. from wounds of the foot, and in 90 per cent. of the puerperal cases.

The disease supervened in two weeks after the injury in 196 cases with 65.5 per cent. mortality. From the fourteenth to the twenty-first days, 81 cases, and 17 per cent. of mortality.

In cases occurring within seventy-two hours after injury, recoveries exceeded deaths 14 to 11; occurring between the fourth and ninth day, deaths exceeded recoveries, as 73 to 33, 69 per. cent.; occurring on the thirteenth day, deaths to recoveries, as 7 to 3, but when tetanic symptoms did not appear until the fourteenth day recoveries were notably in excess of deaths—28 per cent.

In one-fourth of the cases the date of invasion was not given.

Tetanus when fatal was nearly always within the first four days after the attack.

In regard to the treatment he concludes that the "results by the different remedies are so nearly *the same that no one agent can justly be said to possess a decided superiority over any other.*

Amputated Cases	60	per cent of	17	cases	recovered.
Aconite	8	"	00	"	"
Cases Bled	50	"	58	"	"
Calabar Bean	39	"	39	"	"
Cold Affusion	73	"	11	"	"
Division of Nerve	66	"	3	"	"
Indian Hemp	64	"	25	"	"
Ether	60	"	15	"	"
Ice Bags	77	"	9	"	"
Mercury	57	"	75	"	"
Opium	57	"	165	"	"
Purgatives	66	"	74	"	"
Quinine	73	"	15	"	"
Stimulants	8	"	33	"	"
Tobacco	50	"	41	"	"
Turpentine	70	"	16	"	"

Cloroform relieved 70 per cent of 35 cases.

Chloroform ranks in these tables as the most efficient agent yet known in acute tetanus, while even mercury and venesection, which belong to a past age, excel the calabar bean, of which so much was expected.

Only musk, woorara and warm baths fell below calabar bean in efficacy.

Article VII.

THE SPIRIT OF THE EUROPEAN MEDICAL PRESS.

By A. C. Bernays, A. M., M. D., Heidelberg; M. R. C. S., Eng. Member of the German Society of Surgeons, Berlin, Etc.

[In these papers, to appear monthly in the Journal, we propose to give a short resumé of the most important and interesting novelties that appear in the European medical press. By special arrangement we will be able to publish the most recent discoveries and innovations in a very short time after they appear in Europe.]

Prof. Dr. von Nussbaum, of Munich, in a most interesting monograph, gives us the results of his experience as an ovariotomist. He says: "The operation of ovariotomy has some very peculiar features. No operation requires as much experience and courage; in no other operation is the most important feature of an operator, the absolute equanimity in case of the occurrence of something unforeseen, so much called for as in ovariotomy. It is impossible to know what may occur, whether there be adhesions or not, whether there be a pedicle or how long the same may be, etc. Therefore the terrible judgment: that no operator will have as good results in the first 20 cases as in his second or third score can be applied only to this operation The terrible sentence is actually true and it is a blessing that the general public does not know it, because no operator can begin with his 21st case, and consequently the stage of terror must be gone through with. This can positively not be said of other operations. I am firmly convinced that many a young surgeon performs his first amputation just as faultlessly and with as good results as his fortieth or fiftieth. This can not be held with regard to ovariotomy honestly speaking, unless the beginner may have assisted to twenty or thirty operations at previous times."

Nussbaum operates under antiseptic precautions. He always turns the patient on her side before puncturing the cyst, and opens all secondary cysts from within the primary cyst. After this he tries to lift out the tumor with his hand from the pelvis; does not like pulling on the cyst. Only slight adhesions are

torn by the fingers; the longer he has operated the less he makes use of this procedure, claiming that it gives rise to parenchymatous hemorrhage, which is very hard to control; very vascular adhesions are ligated doubly and cut between the ligatures. It sometimes comes to pass that by this means pieces of the cyst-walls up to the size of 1½ square inches are left attached to the small intestines, the uterus, etc. "I have never left a single operation incomplete on account of adhesions, and a very encouraging number of these bad cases have recovered so that my opinion in this respect remains unchanged." In case of uncontrollable hemorrhage from smaller vessels, where adhesions have been torn away, Nussbaum has found it an excellent practice to increase the pressure in the abdomen by the weight of two or three bricks laid upon the dressing of the abdomen.

"I had to dissect the ovary off from the uterus in one case to the extent of about fifteen square inches, but the uterus bled very freely from numerous vessels, so that I did not place confidence enough in my brickbats. Had it been a cyst-wall I should have left the same in connection with the uterus, but it was a firm sarcomatous mass. I covered the bleeding surface of the uterus with a flap of peritoneum, which I dissected off from a neighboring secondary cyst, about the size of a hand, which was in connection with the peritoneum of the pedicle, the vessels of the latter having been ligated after isolation. I used fine catgut for sewing the flap down. In this case, a piece of one ureter was intimately connected with the ovarian tumor, and was removed with the tumor. As I have related in my monograph about the case, it got well rapidly without any disagreeable symptom excepting that a fistula remained about an inch below the umbilicus, out of which one-half of the urine was passed. The patient was very much distressed, and the old appliances that were tried caused great inconvenience and answered their purpose but very incompletely, so that I began thinking about some radical operative means to effect a cure. I did not dare to follow the example of the late Prof. Simon, of Heidelberg, viz: to extirpate the right kidney, because the patient was too weak and emaciated to stand so severe an undertaking. I could not attempt to obliterate the fistula on account of the great amount of the secretion, and in both of the above operations the left kidney would have had to fulfill double the functions it had been used to. Therefore, I followed a third plan: I established an

artificial ureter, or rather a fistulous duct, which led from the reservoir of urine, that had formed below the umbilicus to the bladder. I could not find the vesical orifice of the ureter that had been cut off, although making use of Simon's specula. Therefore I passed a trocar through the urethra and through the cavity of the bladder to a place at the fundus, which I supposed would about correspond to the location of the normal orifice; I then perforated the bladder, and passed my instrument up into the reservoir below the navel. I then passed a drainage tube and after some trouble, I actually succeeded in establishing a passage for the urine into the bladder. It became a very easy matter now to close up the abdominal fistula, and it gives me exquisite pleasure to use my pen and relate that at present, after several years, the new ureter is in excellent function, and that the patient has no notion of the fact that she has but one ureter, and that an artificial fistulous passage is in existence in her abdomen. She lives like a sound person, without a complaint."

After the above most interesting excision, which, in the opinion of your reporter, is the most elegant achievement by a single surgical operation on record, our author relates another most interesting case which I will also present in a few words, using the language of the author where convenient: In March, 1878, Nussbaum undertook an operation for what he supposed to be a multilocular ovarian cystoid. He actually found a multilocular cystoid, but it had no connection with the uterus, and there was no pedicle. The cysts, varying from the size of a fist to that of a child's head, were situated along the lower part of the small intestines, and "I either had to leave the operation incomplete or proceed to cut these tumors away from the intestine. All those present were of the opinion that we were dealing with a degeneration of the mesentery for the cysts were arranged alongside of the intestine. I concluded to remove them and did so with a pair of Cooper's scissors." A piece of small intestine was thus left loose in the abdomen; its length was 15 inches, it had the appearance of a sausage, the mesenterical edge of which was bleeding so freely that it was necessary to apply 14 catgut ligatures. "I confess that we all felt very uneasy about the case; that we feared this piece of intestine 15 inches in length might mortify or lose its function, or perhaps might stop the peristaltic movements, etc., and my first question at each visit was in regard to the vomiting, but I always received a

negative answer. We were all greatly astonished at the desirable course the case took; flatus passed on the fourth day; the first passage was delayed up to the eleventh day by morphine, and the patient left the Institute after six weeks enjoying excellent health.

His remarks about the treatment of the pedicle give us no new methods; he seems to prefer ligating the pedicle in several small portions by means of strong catgut.

In regard to the toilet of the peritoneum he says that it is not necessary to be so very scrupulous when making use of the antiseptic method.

He has found that the most rapid recoveries ensue when drainage is not practiced and has abondoned it unless great uncleanliness of the cavity calls for it.

Nussbaum relates the following curious and instructive circumstance at the close of his paper: "Although I fasten each drainage tube to a long silk thread, it occurred to me in the case of a lady upon whom ovariotomy had been performed, that one tube slipped into the abdomen from the lower edge of the incision and was lost. The wound healed up and one month after her dismissal from the Institute, a ball was given (the 62nd day after the operation) in celebration of her recovery. All the invited gentlemen danced with the queen of the feast, and she became terribly exhausted At 4 A. M., during a gorgeous cotillon she was suddenly taken with severe pains, deep-seated stitches in the abdomen; she could waltz no longer, and in fifteen minutes could not even stand erect. She walked into a side room, and looking at her abdomen, saw a movable black spot in the center of the then painful cicatrix; grasping it with her nails she withdrew a drainage tube $2\frac{3}{4}$ inches in length, wiped off some pus, and feeling relieved of all pain, returned to the ball-room and enjoyed dancing to the end.

Translations from the German.

GLAUCOMA. Excerpts from a Lecture by L. WECKER. [Translated by WM. DICKINSON, M. D., of St. Louis, from *Klinische Monatsblätter für Augenheilkunde* for May, 1878.]

For a long period great unanimity of opinion has prevailed respecting the proximate efficient cause of Glaucoma,—increased intra-ocular pressure and its consequences,—but a considerable diversity exists in regard to the mechanism by which this pressure is effected.

Citing the opinions of authors, Wecker states, "according to the view of Donders, this pressure is the result of increased secretion;" his own, "such a condition in by far the greater number of cases is developed in consequence of impeded excretion." Dr. Knies regards an inflammation of the tissues investing the canal of Schlemm as an essential factor; Weber, that the cause of glaucoma consists only in a mechanical and gradual compression of the filtration passages of the humors of the eye. He also adds, "the filtration passages discovered by Leber can be compressed by the hyaloid tissues, and the excessive development of the epithelial layers covering them; and besides that, glaucoma will be obviated by the restoration of filtration through the agency of a cicatrix." During the discussion of the subject of glaucoma at the Congress at Heidelberg held in 1877, it was maintained that closure, i. e., obliteration of Fontana's space, does not in and of itself induce glaucoma, but on the other hand it more frequently occurs while Fontana's space remains free; and Pagenstecher states that in by far the greater number of cases of eyes lost from glaucomatous processes, the iris and ciliary body undergo material changes. It was also held that glaucoma is occasioned by a defect of filtration, and that the fundamental cause of increase of pressure must be sought in the eruption of impediments which have developed in the filtration passages. These impediments may be occasioned through the agency of the iris and the lens, which latter crowds against the iris-angle and causes obliteration of Fon-

tana's space; yet these cannot be regarded of the character of those which as antecedents necessarily result in the production of the principal forms of glaucoma, viz: acute, chronic-irritative and the simple chronic. It is the obstruction of the filtration passages in which is involved the question of glaucoma.

The filtration passages, according to Leber, are: 1st, the tissues surrounding the cornea; and 2d, those investing the optic nerve entrance (papilla). These are the only parts of the interior of the eye that are not covered by a transparent membrane (glashaut), which same is little adapted for filtration. The principal filtration avenue is certainly situated around the cornea, just where the anterior chamber by means of the trabecular tissue obtrudes itself, as it were, beneath the conjunctiva. In this region the union of the various lymph passages takes place, viz: of the cornea, sclerotica and the membranes of the interior of the eye with the great lymph space, which we call the anterior chamber of the eye. Impediments, which may be developed in this trabecular tissue, whether they arise from the chambers of the eye, from the sclera or in fine from the conjunctival side, will hinder the transudation of the humors of the eye into this principal filtration avenue (haupt filtrationbahn).

How is this infected circle (circulus vitiosus) developed, which when once affected by an anomalous increase of pressure surely threatens more and more to shut up the filtration passages? According to my opinion it is determined by an increase of pressure, accompanied by some change in the form of the globe, which through compression of the trabecular tissue at the iris-angle occasions impediment to filtration.

In that form of chronic glaucoma which is entirely free from symptoms of irritation, and in which increased pressure exists only in a slight degree, and the most essential appearance of disease consists in the recession of the optic papilla (staph-post), we must seek for the impediments, not in the great filtration avenues of Leber, but in the small ones situated around the optic nerve.

We especially insist that the development of glaucoma is *par excellence* favored by a deficiency in the elasticity of the sclerotica. This defect of elasticity on the one hand renders impossible any compensating adjustment for the small (it may be) and antecedent increase in the contents of the eye; and on the other facilitates the production of the infected circle already

referred to, that is, through the increase of pressure which on the part of the sclerotica is especially unyielding in its external layers, the apertures of filtration proceeding from the anterior chamber will be so much the more compressed, as the intensity of pressure increases.

Glaucoma, which, as statistics show, constitutes one per cent of all diseases of the eye, usually supervenes when signs of senility begin to appear, that is, about the fiftieth year. At this period fatty degeneration and calcareous deposits take place in the sclera (Coccius), and also a considerable thickening of the tissues in the vicinity of the filtration passages. Under these conditions the eye may acquire such a degree of fullness that the addition of the least drop will develop this affection. This will take place, for example if, simultaneously with the existing atheromatous, varicose or aneurismatic changes, rupture of them should occur. A like condition may ensue, if, after the instillation of atropine, the expansion of the blood vessels is sufficient to induce an excessive fullness of the eye to such a degree as to interrupt the equilibrium between secretion and excretion, and through the establishment of the diseased circle to render this accident a permanent condition. In an eye affected with such proclivities a mere congestion of the vessels, even for a short period, may occasion such a disturbance of equipoise; and violent emotions of the mind are able to bring an impending glaucoma to its outbreak (ausbruch). An old lady (related by Fischer) who was very much affected by her loss at the gaming table, speedily lost vision in one eye from glaucoma. Having been positively forbidden the indulgence of this passion she for a time obeyed; but, subsequently, having one day yielded to the temptation she unfortunately was again a loser to a large amount, and during the night following she became *totally blind and so remained.* Fear also may be the occasion of glaucoma. During the siege of Paris, a prominent engineer, fifty-six years of age, having left the city in a balloon, happened to descend in the country of the enemy; and, being made a prisoner, was conducted to prison. He soon observed a rapid diminution of vision from glaucomatous processes, which assumed the chronic form; for which, however, an iridectomy was performed with good results.

Again, a lady of fifty-two years of age, of good social position, having been detected in the act of stealing an article of trifling

value from one of the stores of the capital, was arrested and taken to prison. She suffered an immediate attack of irritative glaucoma in both eyes, from which there resulted speedily a deep excavation of the papilla, accompanied by a considerable reduction of vision. Farther deleterious consequences were arrested by iridectomy in both eyes.

Though injuries, such as the introduction of a foreign body to eyes that are predisposed to an interruption of the normal equipoise between secretion and excretion, will not occasion an excessive secretion of the humors of the eye, yet they may occasion such a distension of the vessels as will suffice to induce a disturbance of the equilibrium. This traumatism with the temporary congestion that usually accompany it, will in the case of a young person, in the eye injured, meet with a compensating distension of its enveloping tunics, due to their greater elasticity. But this cannot occur in an organ affected with considerable senile changes, the filtration passages of which are narrowed to such a degree that, of necessity, the normal amount of nutritive material secreted cannot be discharged. Amid such conditions, a very slight increase of tension will suffice to close up entirely the infected circle of which we have made mention. Till recently it was entirely impossible to understand why glaucoma occurred with greater frequency in certain races (Jewish), and in certain families. It is now known to occur in persons whose sclera by nature is sparingly distensible, and the filtration passages consequently are capable of yielding but little; or whose sclera has been invaded in such manner that their closure cannot readily take place in consequence of the senile changes developed in them. On the other hand, if glaucoma is rarely met with in many nations (Arab races of the interior of Africa) it must not be forgotten that all the fibrous tissues in these people are very pliant and manifest but little tendency to fatty degeneration. Still, in these races, instances of consecutive glaucoma, following penetrating wounds of the cornea, are not infrequent, occasioned by a sudden and considerable shutting up of the filtration passages." The remainder, devoted to the neurosis in consequence of which this affection supervenes, will be considered hereafter.

PETTIS COUNTY MEDICAL SOCIETY.

At a regular meeting of the Pettis County Medical Society, held at Sedalia, Mo., August 26th, 1878, the following proceedings transpired:

Dr. W. H. Evans, President, in the chair. Members present: Drs. E. C. Evans, Trader, King, Jones, Mayfield, J. A. C. Brown and Neale. Visiting Brother: Dr. A. V. Small.

There having been no regular meeting for nearly twelve months, and the previous minutes being incomplete, were read, and, on motion, Dr. King was appointed to assist the Secretary to correct the minutes and place them on record, after which they were approved.

There being no unfinished business, the resolutions to amend Article VII of the by-laws was taken up, viz.:

Resolved, That no member of this Society shall be allowed to consult with any physician who is in the habit of consulting with irregulars or quacks, under penalty of expulsion.

After considerable discussion upon the resolution it was unanimously adopted.

There having been no election of officers at the usual time, on motion, the regular order of business was suspended and the officers who were filling the offices were instructed by a vote of the Society to hold over until the next annual election, on the 4th Monday in July, 1879.

There being no report of committees, and nomination of candidates being in order, Dr. E. C. Evans nominated Dr. A. V. Small for senior membership. Dr. Mayfield nominated Dr. Bronson for senior membership.

Dr. Bronson had withdrawn from the Society that he might engage in advertising.

Drs. Trader and Mayfield were appointed a special Committee on Election of Drs. Small and Bronson. The committee reported favorably on Dr. Small's petition. He was therefore elected a senior member, and took his position as such. The committee then asked for further time on Dr. Bronson's case, and for instructions of the Society upon what grounds he shall be received into the Society again. The instructions were "to investigate how far he had violated the medical ethics, and to readmit him, provided that he make known entirely and fully the secret remedy that he had been using in his practice.

Dr. Jacob B. Jones then presented his petition of withdrawal from the Society, having paid his back dues for the last two years past, that he might have the opportunity to advertise. This he done to a greater extent than is allowed by the medical

ethics. After considerable discussion on the subject, on motion, he was allowed to withdraw by a vote of the Society.

On motion of Dr. Trader, $20 of the money in the treasury was appropriated to Dr. Christy, who has for some time been paralyzed. On motion, Dr. Trader was appointed a committee on behalf of the Society to present the amount to Dr. Christy.

On motion, the officers of the Society are to present a written report of their official work for the past year.

On motion, the Society was directed to send to THE ST. LOUIS MEDICAL AND SURGICAL JOURNAL, for publication *hereafter*, the minutes of this Society.

On motion, Society adjourned until the fourth Monday in September, 1878.

SEPTEMBER 23rd, 1878.

Society met pursuant to adjournment, Dr. Dr. W. H. Evans, President, in the chair. Members present: Drs. Mayfield, Small, Trader and Neale.

The minutes of last meeting were read and approved.

There being no unfinished business, and reports of committees being called, Drs. Trader and Mayfield handed in a report on the case of Dr. Ira T. Bronson, which was read and placed on record, viz.:

We, your special committee on the application of Dr. Ira T. Bronson to be reinstated to the Pettis County Medical Society, have the honor to report that, in our opinion, the Society would not be warranted in entertaining said petition.

Dr. Trader then offered a resolution which was adopted by a vote of the Society, viz:

Resolved, That in case any member of this Society may see fit to withdraw for the purpose of practicing illegitimate medicine, contrary to the spirit and letter of the ethics as adopted by the American Medical Association, we cannot reinstate him upon petition or recognize him as a regular practitioner of medicine.

Drs. Trader and Mayfield, as special committee on Dr. W. O. Dunlap's petition for senior membership, reported favorably, and the Secretary was directed to notify Dr. Dunlap of his election.

The Treasurer then made his report for the past year, which was received and approved.

Dr. Mayfield offered a resolution for the protection of the members of this Society from imposition by those who "deadbeat" their bills, to be known as the *black list*, viz.:

Resolved, That each member of this Society residing in the City of Sedalia be required to report a list of all patrons who refuse to pay reasonable medical bills, and who are not objects of charity; and that no member will be at liberty to attend professionally such persons or families until such bills have been paid.

This was adopted by a full vote, and directed to be placed on the records.

On motion, the Secretary was directed to have a number of blanks printed of said list for the use of the members, with the above resolution printed thereon.

On motion, the Secretary was directed to have a number of certificates of membership of this Society printed for its use.

Dr. Trader made a motion that the Secretary receive a salary sufficient to enable him to attend to the duties of his office, and to employ an amanuensis, if necessary, to keep a good and neat record of the Society.

Dr. Trader was appointed to read a paper before the Society at its next meeting, after which the Society adjourned.

OCTOBER 21st, 1878.

A called meeting, Dr. W. H. Evans, President, in the chair. Members present: Drs. Mayfield, Trader, Small and Neale.

The minutes of the last meeting were read and approved.

There being no unfinished business, the President stated that the meeting was called to hear a paper from Dr. Trader, entitled, "Our Surroundings." On motion, the paper was received and directed to be sent to THE ST. LOUIS MEDICAL AND SURGICAL JOURNAL for publication. Very complimentary remarks were then made by the members present upon the merits of the paper.

There being no more business before the Society, it adjourned until next regular meeting.

I. R. NEALE, M. D. Secretary.

OUR SURROUNDINGS. By JOHN W. TRADER, M. D., of Sedalia, Missouri.

Man is not only, to a great extent, the creature of circumstances, but he is being constantly wrought upon after coming into life by his surroundings. The theory of the "survival of the fittest" does not apply to race alone; but the elements in which we move may overcome us and fashion us after their own liking. Cannibals inhabit the forests with carnivorous animals and partake of their natures. The nude denizens of the tropical clime divide their time with the sloth. All nature to them is sluggish. The streams barely move in their quiet journey to the sea. There are no cataracts, no bounding mountain torrents to awake nature from its slumbers. Men come and go with a tardy step, and scarcely conjecture why they live. The beautiful powers of the imagination that are born of flowers and songs

and the sweet murmur of the brook lies dormant in the chambers of thought. There is a purer atmosphere encircling the hills. We are taught that better, that holier life from the summit of Mount Sinai, while confusion of tongues and discord are engendered in the plain. Heroes come from the mountain's crag and insecure dalliance from the valleys below.

This is not altogether fancy. I speak the truth, devoid of figure, when I say that you and all of us are feeling the influence of our surrounding to-day.

Who is it that will deny the power of association upon our social being? Now, as thousands of years ago, is the fact demonstrated that "evil communications corrupt good manners," and that "the companion of fools shall be destroyed." No less is our physical being influenced and molded by the place and circumstances in which we live. The ruddy mountaineer, like the deer of his native highlands, sleeps with his feet well under him, so that by a single bound he may be out of danger. Diseases are as indigenous to locality as are the fauna and flowers. Not that species will not distribute, but that in unfavorable surroundings they can not develop their powers. Take the puny deer of the Louisiana lagoon and compare him with his stately brother of the north, and you can hardly recognize the same species. So also in regard to the human race. Take an indigenous stock whose ancestors for generations back have inhabited the low marshy lands, and as he leans up against his adobe shanty like a new-made moon, you can scarcely detect the brotherhood that exists between him and his full-orbed kinsman of more salubrious climes. Let the surroundings be unfavorable and no extra effort can conquer the tendency to degeneration. Intellectually, morally and physically this decay and blight is surely going on. No doubt but there are bright spots, and gentle zephyrs that fan them as they lie imbedded in the old ocean. Songs there may be, but they are only songs of requiem. The intelligence that sparkles in an unfavorable zone, and like a meteor lights up everything for a moment in its train, is a mere wanderer from higher plains. No progeny is left to take their place, and the good they had was interred with the bones.

Whatever cause may operate to physically impair the individual materially affects him in all the relations and duties of life.

Taking advantage of this fact we wish to call attention to the physical conformation of the earth in relation to the distribution of diseases.

Geographically speaking, the disease realm is marked by lines of moisture north and south of the equator. "There are facts to show that some diseases are so completely under the influence of temperature that they are susceptible of being arranged systematically in zones of geographical distribution." Isothermal zones bear a most prominent part in relation to the distribution of all

zymotic disorders. They connect various parts of the earth which have the same mean temperature. Humboldt was the first to notice this fact and point out its existence. Satreille was the first to notice this peculiarity existing in the insect realm. Malarious fever, yellow fever, typhoid fever, plague and typhus fever have their particular zones, and rarely ever invade districts of country remote from their habitat unless the conditions of their life are complied with, either in climatic changes or accumulations of filth. The fortieth parallel north and south of the equator will probably limit the isothermal line of Humboldt, in which the mean temperature rises 77°, and which becomes the home and breeding place, so to speak, of those thermal fevers. They rarely occur beyond this their natural limit unless invited thither by some unusual occurrence, and then never become indigenous. All paludal fevers of this type select low flat countries, the altitude rarely exceeding 300 feet. The great centers of these malarious diseases in America are the shores of the Gulf of Mexico and the low lands of the South. The mortality from them reaches as high as 75 in 1,000, and yet this fearful mortality does not seem to attract attention unless some sweeping epidemic as the yellow fever the last summer in the Southern states sweeps over the country and appals by the magnitude of its destruction. North of the fortieth parallel the character of the diseases change. We now have a more sthenic form. Catarrhs, colds, rheumatism, inflammatory fever and consumption prevail.

It is not claiming too much for science to say that ample means may be provided against the propagation of these diseases. Both North and South the disorders that afflict man may be so far modified that the death rate can be reduced from the fearfully high one above given to 8 or 10 to the 1,000. As to epidemics, there can be no cause operating ever so fiercely, but may be changed and rendered in a manner harmless or removed altogether. In the South we want better drainage and a thorough interment or incremation of all decaying animal matters. In the North we want better homes—homes that do not invite disease by irregular temperatures and bad ventilation. Miss Nightingale, in her pamphlet "How to Live and not Die in India," did much in bringing before the English government the necessary improvements urged by the local Army Board.

Let the main cause of disease in India—want of drainage, want of water supply, want of proper homes—"remain in all their primitive perfection."

After we have redeemed the land from those natural disease-producing causes by drainage, etc., we, on the other hand, must see to it that we do not become our own destroyers. The deleterious emanations of all carnivora or flesh eating animals are eminently poisonous. Modern science, or, more plainly speaking, common sense, teaches us that this great evil, the

source of so much misery and death among the human family, can in a great measure be remedied or avoided altogether. In that admirable system of laws which governed the Jewish people, and which we look upon as being of Divine origin, our physical as well as our spiritual well-being has been amply provided for. What do you suppose would have become of the Jew who would have cast the refuse of his body into an overflowing cesspool which, by its stench and putrefaction, would have not only made the surrounding atmosphere unpleasant, but absolutely hurtful and dangerous to every one breathing it? We know that if nothing worse had befallen him expatriation from Jewish fellowship would inevitably have followed such a course. The Jew was commanded that, when he should go out to ease himself he should not only go without the camp, but he should provide himself with a paddle and carefully and effectually cover up the excretion of his body. We see, also, instinctively implanted in the nature of carnivorous animals a command for a like service. The dog and cat, our most familiar domestic animals, exhibit the impress of this law. Not so perfect, it may be, as when they roamed unrestrained in their native forests and plains, but a law nevertheless. Their association with man may have had something to do in causing existing discrepancies. Dogs, like men, are prone to depart from rectitude, town dogs and town men are notorious in this respect. The importance of this one fact, that the defilement of our own bodies brings disease fierce and fatal upon us, it would seem should have long since established a law of expedience, if nothing more, to correct this evil. Does it not appear absurd to rational beings that this great sin of uncleanliness (for it is nothing more nor less), should remain so patent in a day and age of such universally diffused knowledge? Yet this is the case. City councils and municipal authorities, in many instances, although convinced of the importance of these sanitary reformations, refuse to act. The long funeral cortege moves silently on, while the mourners sigh over the sad dispensation of Providence, not stopping to think that within the limits of their own powers lies the remedy for all this woe. But then we have cause to hope. The people of this age are becoming too intelligent and cultivated to refuse obedience to the just demands of a well regulated state medicine. The time has come when dirty streets and pent up sewers shall be disgraceful to a community. And when we have cleansed our streets and purified our alleys, we should see that there exist no pestilent-breeding nidus in our homes and around our firesides. A very intelligent lady has said that typhus fever may exist in a dirty dish-rag, and modern science and common sense will certainly endorse the assertion.

October 21st, 1878.

ROLLA DISTRICT MEDICAL SOCIETY.

Synopsis of the proceedings of the Tenth Semi-Annual Meeting in Rolla, Phelps Co., Mo., Tuesday, Nov. 26th, 1878.

The Society met in the Court-house, and was called to order by Doctor S. S. Harris, Vice-President.

Dr. J. T. Coffee was appointed Secretary *pro tem*, and the minutes of last meeting were read and approved.

Drs. Glenn, T. J. Jones, and McManigle were appointed a committee on programme and order of business, after which the Society took a recess until 2 P. M.

AFTERNOON SESSION.

The Society met at 2 P. M., Dr. Harris in the Chair.

Committee on Programme reported, and Dr. W. E. Glenn, from the Special Committee on "Expert Testimony," appointed at the last meeting, presented a lengthy and thorough report in which the usages in Iowa und other States, as well as the decision of the Supreme Court of Indiana in the case of Bochman *vs* the State of Indiana, were cited.

He reported further that, acting on the expressed views of the members during the preceding meeting, the chairman of the committee refused to testify as an "expert" in the Circuit Court in Phelps County without the recognition of a proper fee. A lengthy discussion followed, when Judge Hill decided, in view of the decision quoted, of the Supreme Court of Indiana, that while he could not require the payment of extra compensation, he would not in future consider such refusal a contempt of court, punishable with fine or imprisonment, and notified the members of the bar to make their own arrangements with "expert witnesses" prior to producing them in court.

The report concluded with a resolution requiring members to take a decided stand on this question, and requesting the State Senator of the district to bring the matter under the consideration of the next General Assembly.

The report and resolution were both adopted unanimously.

Dr. McManigle asked the opinion of the Society as to the propriety of removing a tumor, large as the closed fist, attached to the lumbar region of a new born infant. It was deemed entirely safe and advisable, under the circumstances, to employ a rubber ligature.

Dr. Coffee read an interesting paper on "Fevers," which evoked considerable discussion, in which Drs. Jones, Headlee, Lenox, Bradford, McManigle, Harris and Glenn freely joined.

Dr. Glenn remarked that the discussion of such familiar subjects with which all were so conversant, abounded with inter-

est that never wearied, every one having experiences that were instructive and of practical utility.

Dr. A. L. McGregor presented a case for consideration and the diagnosis of the Society. The patient had a mush-room-like growth on the floor of the mouth of four months' existence. After examination, the opinion was divided between epithelioma and epulis, a majority inclining to the latter. Treatment recommended, excision. The meeting then adjourned to 7 P. M.

NIGHT SESSION.

The Society met promptly at 7 o'clock.

Dr. McManigle reported two cases: The first was one of imperforate hymen. The sufferings of the patient, who was fifteen years old, were very great and had continued for some fifteen months. After considerable difficulty and opposition he succeeded in obtaining an examination. Assisted by Dr. Harris, he punctured the tense and bulging hymen, liberating half a gallon of extremely fœtid and dark colored fluid, with immediate relief. So averse was the girl to any examination that it became necessary to hold her.

The event was quickly heralded through the country neighborhood, and the relif or cure so apparent and pronounced, that the Doctor had an immediate application from a couple who had been married nine years without sexual congress being effected. An examination of the wife developed vaginismus of so severe a character as to prevent admission even of the little finger, the spasm and pain being uncontrollable and intense. Not having Sims' dilator, Dr. McManigle made one out of hard wood and succeeded in a short time in producing the necessary dilation, which permitted sexual intercourse for the first time in their married life. The lady is now pregnant and her perfect cure assured.

After a highly interesting and pleasant meeting, adjourned to meet in Rolla, on the last Wednesday in May, 1879.

T. J. COFFEE, Secretary, *pro tem.*

SOUTHEAST MISSOURI MEDICAL ASSOCIATION.

The following is a synopsis of the meeting of the Medical Association:

The Fourth Semi-Annual Meeting of the Southeast Missouri Medical Association, convened at Cape Girardeau, Tuesday morning, December 3rd, 1878. Although the attendance was small, yet the meeting was most interesting and instructive.

Each member seemed to think, as the attendance was small, it would devolve upon him, to perform additional duty in order to compensate for the loss in number, and suiting the action to

the impulse, took hold and worked with a vim and energy that characterizes the workings of very successful meetings.

This Society, although, yet in its infancy, is on a basis so firm that it may be classed with the permanent organizations of the country, its membership now numbering just forty; and among that number may be found the names of the ablest, most enlightened and learned physicians in Southeast Missouri.

Several papers were read, and each was exhaustive upon the subject treated of. The merits of each paper, pro and con, were taken up and freely discussed.

Several cases were cited in full, including the nature, cause, duration and treatment of the subject under consideration. A very important part omitted is that of the Counselor's reports of the various counties. Dr. W. B. Wilson, of Cape Girardeau, being the only counselor present, his report was brief, but to the point.

The Society received the reports of several committees. Perhaps the most important was on Constitution and By-Laws. The report was received and the committee discharged. After being read the second time the Constitution and By-Laws were adopted, as amended. The adoption necessitated the appointment of several committees, and a Corresponding Secretary. The committee most worthy of note, was the one on Petitions for Membership. The Chair appointed Dr. W. B. Wilson as Chairman, with Drs. Henderson and Harris as assistants. The Chair also appointed Dr. C. G. Wilson, the present Recording, as Corresponding Secretary to fill the unexpired term.

The citizens of Cape Girardeau were exceedingly kind and hospitable. The Turners tendered the use of their hall, proposing to light and warm it, free of charge. The Court House was also tendered. Prof. Dutcher, principal of the Normal, extended a very cordial invitation to the Society to visit the school, which they did *en masse*. Dr. W. B. Wilson gave the Association a dinner on Wednesday, and the physicians of the city a supper at the hall, at the close of the evening session.

A most interesting case presented for examination was that of Dr. W. B. Wilson, of an ulcerated toe, wherein the original toe had been amputated, and the parts, instead of healing by first intention, gaped open and inclined to slough. The Society concurred in the treatment as adopted by the Doctor, and urged him to continue the treatment already established. Another case was that of Dr. Rider, of a fibrous tumor on the right lower lid, near the outer angle of the eye. The instructions of the Society were to operate.

In my enumeration of committees I failed to notice the appointment of Committee on Essays, of which the following is a summary: On Obstetrics, Dr. W. B. Wilson, of Cape Girardeau; On Diseases of Women, Dr. Wm. Nifong, of Fredricktown; On Surgery, Dr. C. G. Wilson, of Cape Girardeau; On Prac-

tice of Medicine, Dr. J. D. Porterfield, of Commerce; On Cholera Infantum, Dr. A. A. Bondurant, of Charleston. A motion prevailed requesting Drs. Mann, of Perryville, and Rider of this place, to deliver at our May meeting a debate on the "Doctrine of Humeral Pathology." Dr. Mann assumes the affirmative and Dr. Rider the negative. The Society is expecting a treat of rare merit.

Adjourned, to meet at Charleston, the county seat of Mississippi County, on the first Tuesday in May, at 7 o'clock P. M.

C. G. Wilson, M. D.

Cape Girardeau, Mo., Dec. 9th, 1878.

Clinical Reports from Private Practice.

Amaurosis Puerperalis Transitoria. By Dr. Carl Walliser, M. D., of Highland, Ill.

Mrs. B., aged 18, primipara, from Highland, Ill., gave birth to a child on the morning of October 7, 1878. She was greatly depressed, having lost her eyesight during the last labor pains. I was called in the next morning and received the following information from the midwife: Labor began at 7 A. M.; at 10 A. M. the liquor amnii flowed; head in first presentation. As the midwife had an appointment in the country, and being unwilling to abandon the patient before the final delivery, she ordered her to assist by pressing as hard as possible. The child was born before 11 A. M. At the very instant when the occiput passed, the woman fell into convulsions, and the hitherto strong labor pain ceased. The child, although alive, soon after died. The afterbirth followed half an hour later, and could only be tracted after several applications of Crede's method. As the midwife was formerly in the habit of pulling the cord, I had advised her the use of the less dangerous method of compression upon the abdominal wall. There was no hemorrhage.

The convulsions ceased soon after 12 M. At this time the patient asked her nurse to light the lamp in order to see her baby. She could hardly be convinced that it was broad day

light; from this time on until my arrival early next morning her anxiety on account of loss of sight constantly increased.

On examination twenty hours after delivery, her head was red and somewhat painful to the touch. It showed a much higher temperature than the remainder of the body. The expression of her face was one of suffering. Although she was fully conscious, her sadness was so deep that I feared a fatal issue. Skin dry; tongue moist; neither appetite nor thirst; no alvine evacuation for three days; pulse 104; temperature in the axilla, 38.5° C; eyes staring, both pupillæ rigid, dilated, not sensible to light. Her excitement did not permit an ophthalmoscopic examination. Her breasts were almost empty. The inspection of the vulva showed several small superficial rents and a deeper one; vagina narrow, conjunctivæ not shortened; os tincæ lacerated; canalis open; discharged lochia fœtid; urine containing some albumen.

I ordered 20 grains of calomel to be taken in 5 grain doses every two hours; application of ice on head and neck; vaginal injections of a three per cent solution of carbolic acid every three hours; a bag impregnated with carbolic acid to be applied on the wounds and to be removed frequently. I insisted upon the midwife invariably washing her hands and anointing them with ten per cent carbolic oil, previous to any injection or exploration.

On my next visit the patient was in very low spirits, although her physical condition had improved. She had had several liquid stools, also good perspiration during the night, but she was afraid that she would never regain her eyesight. Pulse 94, temperature, 38° C. As I approached a burning candle to her eyes I thought I noticed a slight contraction of the pupillæ. The patient was now able to distinguish light from darkness and to tell correctly whether the candle was burning or not. Discharges of the genitals without fœtid odor; rents healing. On the next day both temperature and pulse were normal and the patient counted correctly the number of fingers held up before her. From that time she improved rapidly, and was able to read a newspaper two weeks after delivery with perfect ease.

I recollect another case of amaurosis transitoria which occurred some years ago, during my hospital practice in Germany: A young man suffering from stenosis valvulæ mitralis, became suddenly blind in consequence of a mental excitement. Ophthalmoscopic examination resulted negatively.

Correspondence.

CHICAGO, Dec. 17, 1878.

EDS. JOURNAL:—I enclose you a short article for your journal with the following object: The carbolized hypodermic injection of hemorrhoids practiced by the itinerants is a valuable treatment provided it is safe. I discovered and published their secret some two years and a-half ago, but suggested that the throwing of carbolic acid into venous tumors might involve a risk of fatal embolism. So much time has elapsed that, it there be any real danger, it should by this time be manifest, but if there is no risk the plan is a splendid improvement. My object is to get information from the whole of the adjacent States, and then to prepare an article giving the results of the inquiry. For this purpose I have sent a similar paper to two or three other journals, and will communicate my results to you and them simultaneously, I shall also employ private correspondence in the investigation:

IS THE HYPODERMIC INJECTION OF PILES DANGEROUS?—About two and one-half years ago, I discovered and published to the profession the secret method of the itinerant "pile doctors."

The plan of these itinerants, which was held as a secret, and at a high price from one quack to another, is substantially as follows:

A hypodermic syringe, with a very firm, sharp point is charged with a strong solution of carbolic acid. Generally three parts of crystalized acid to one of bland oil are employed, but they sometimes combine in equal parts, and for the oil occasionally substitute glycerine.

The method of the operation is to insinuate the point of the syringe into one of the piles, and throw in a few drops of the solution. This causes the hemorrhoids to turn white and gradually wither away. Another one is then attacked, and thus by degrees a complete cure is effected without causing enough irritation at any time to take the patient away from business. The operation is sometimes painless, but in other cases decidedly otherwise.

Attention was called to the seeming danger that, by this method, the carbolized oil might be thrown directly into the dilated hemorrhoidal veins. The injection of coagulants into venous enlargements of other parts of the body has, in a few cases, caused sudden death by embolism, a portion of the clot being carried to the heart and thence passing into, and blocking up the pulmonary artery. It was suggested, therefore, that

the injection of hemorrhoidal veins might involve the same risk. The three groups of hemorrhoidal veins intercommunicate, but the main outlet of the lower and middle groups is to the internal iliac and thence to the heart, while that of the upper is to the portal vein. It is conceivable that dislodged clots or globules of the injection might be swept by the current of the blood to the heart, or, possibly, might pass through the upper plexus into the the portal vein, and be lodged in the liver. I learn that a number of the itinerants have taken warning from my suggestions of danger, and employ a sort of clamp forceps to compress the base of the pile for a few moments at the time of the operation, thus hoping to prevent the passage of clots or globules along the veins.

This method has now been in use over three years, and has been applied to thousands of persons. If there be any actual danger in it, such as is suggested by anatomy, and by the dangers of similar injections in other regions, by this time the result should be manifest. Experience only can settle such matters; if on the other hand the method is safe, it ought at once be adopted by the regular profession as the best method of dealing with this distressing disease.

To settle this question of danger, I take the liberty, through the columns of this JOURNAL, of asking every physician in the United States, who has had an opportunity to know the results of this treatment, to write to me immediately, giving information on the following points:

1. How extensively has the plan been tried in your region?
2. How far is the plan painless or otherwise?
3. Have any sudden deaths or other alarming symptoms been known to follow its application, and how soon, and what were the symptoms?
4. Have any cures been followed by dangerous disease of the liver?

I propose to collect all the information thus gathered, and communicate the result in a future article through the pages of this JOURNAL. Please address,

EDMUND ANDREWS, M. D.

No. 6 SIXTEENTH STREET.

THE PROPHYLAXIS OF YELLOW FEVER.

EDITOR JOURNAL:—The proposition made by me in a letter to you last summer, relative to the freezing out of yellow fever, is not so impracticable as you seemed at the time to think.

If this monster plague is ever managed the teachings of nature must be followed. His voice has already been heard and the plague has for the time been stayed.

The present winter appears likely to be a mild one and an early spring and summer may bring back all the horrors of the past, unless our medical brethren in the South are wiser than they have been heretofore.

When the first cases appear next summer, if yellow fever should then come again, let no more efforts be made on the part of the physicians to the South to convince themselves that the cases are only bilious or malarial, but let the facts be candidly admitted, and the spread of the disease combatted by the only known means in their power namely, the free, unstinted use of ice.

Let cargoes of ice be placed in the infected localities, piled in suitable quantities about the doors and windows of the infected houses, the opening of sewers and privy and gutters, and even in the rooms of the sick.

When a patient is suspected of yellow fever let him or her be placed in a room, remote from the rest of the family, and a cold room, placed between ice deposited in tubs will answer the purpose, so that the nurses are disinfected as they pass from the sick one.

Let the first infected town and vessels be quarantined with cold. Let every suspected person, passing from an infected town after being bathed, be subjected to a freezing temperature, and put on clothing that has been once frozen.

After cleansing an infected steamer or sailing vessel let the hold and every part be frozen out thoroughly with ice and salt, or sulphuric ether. The plan would be less expensive than the funerals that will follow its neglect, to say nothing of other more important considerations. It is practicable and can be carried out, though I have not now the time to write *in extenso* on the subject. Yours truly, C. H. HUGHES.

Book Notices and Reviews.

AGNEW'S SURGERY. Volume I. THE PRINCIPLES AND PRACTICE OF SURGERY. Being a Treatise on Surgical Diseases and Injuries. By D. HAYES AGNEW, M. D., L. L. D., Professor of Surgery in the Medical Department of the University of Pennsylvania.

The author begins his work with a chapter on surgical diagnosis, which indicates something of the character of the writer and of the book which is now presented to the profession. He is evidently a careful, methodical and honest worker in the practice of his profession. The judgment and advice of such a man is well worthy of consideration, and his large experience and widely-extended knowledge have enabled him to present to us a surgery which will be a safe and judicious counselor to the practitioner. The book is carefully prepared, accurate in its details, and often exhaustive in its research. The author asserts that the surgeon must also be a physician; and he certainly appreciates the fact that a careful analysis of the case and an impartial judgment of its necessities are more important elements of a surgeon's character than mere manipulative skill, however necessary that may be.

In his chapter on Inflammation, he states somewhat concisely the present views on that subject, bringing the subject fairly up to the present time, but leaves, of course, unsettled the uncertain and disputed points, which no theorist can establish, and which can find their solution only in facts to be gained in the laboratory of the physiologist. He then gives a synoptical review of the history of the nature and causes of inflammation which is interesting in the light of our present knowledge, and especially so to those of us who have not studied its history, who have not time to trace the many changes in its theory.

His chapter on wounds is well considered, describing not only the different wounds, but the accidents to which they are liable in their progress toward a cure.

In excision of the infraorbital nerve he gives preference to the old semilunar incision with base on infraorbital ridges, and the use of the trephine, merely mentioning the division of the nerve near the spheno-maxillary fossa by tenotome and its subsequent extraction by pulling on the nerve at its escape from the infraorbital foramen, an operation which has the sanction of Langenbeck, and which is certainly less destructive and equally as certain in its results.

In excision of the inferior dental nerve, he says, "I make a horse-shoe flap over the ramus of the jaw and masseter muscle, convex downwards, one inch and three-quarters in its vertical extent, reaching almost to the base of the jaw, and one inch and a-half in its diameter. This flap is then raised upwards, exposing the ramus, the external wall of which must next be cut out with a trephine, applied half an inch above its angle, and about five-eighths of an inch behind the last molar tooth."

"The nerve which will be exposed with its accompanying artery in the inferior dental canal, should be removed to the full extent of the opening made by the trephine. The bleeding which follows the division of that artery will sometimes prove obstinate. In one case I was compelled to apply the actual cautery, though usually compression or a plug of soft wood forced into the orifice of the canal for twelve hours will be all that is necessary. The wound in the soft parts should be adjusted with two or three interrupted sutures and treated as though it were an ordinary incision."

After mentioning one or two other operations, he passes to another subject without noticing, in any way, an operation devised and practiced by Dr. Jno. T. Hodgen, of this city; an operation simple in its character and efficient in its results; one which leaves no deforming scar to mar the pleasure of the relief it brings. In this operation the nerve is reached by cutting through the mucous membrane and tissues covering the jaw behind the molar, at the junction of the ramus and body, and is described by the author in the Transactions of the Association of the State of Missouri for 1876, on page 25, as follows:

"With a strong knife, a cut one inch long, well down upon the bone, is made in the length of the jaw, beginning at the base and a little to the inner side of the coronoid process of the inferior maxillary and extending forward. The periosteum should now be separated to the width of one-fourth of an inch.

A small drill, driven by a dentist's engine, has its point placed one-fourth of an inch in front of the posterior termination of the incision and directed downward and backward. The firm shell of the bone is soon penetrated, and this will at once be recognized by the hand of the operator. Any resistance to the right or left will indicate to the surgeon that the hard shell on the outer or inner side is being cut, and the drill should be turned in the opposite direction, so that it will be kept in the open porous tissue filling the dense case forming the outer layers of the bone. In a few seconds the canal containing the nerve will be reached, and its thin wall opened. A twinge of severe pain with a more free flow of blood, announces that the nerve and vessels have been cut, and this should be done as near as possible to the entrance of the nerve into the posterior dental foramen. Now a burr replaces the small drill. With this the opening is enlarged, the nerve again reached, and this may be known of course by

the pain when the central end is touched. The free end of the burr is directed forward, and the nerve cut toward its distal termination, and as the central end is not disturbed, this will be painless. Loss of sensibility in the lip, chin and gums attest the success of the operation. Hemorrhage soon stops of itself, or if it continue (as it has not done with me in any case) the opening in the bone affords every desired facility for making pressure by plugging. I am indebted to Dr. Wm. Morrison for the suggestion that the drill be first used to open the bone and the burr afterward to remove a longer section of the nerve." Dr. Hodgen, now in addition, when necessary, makes an incision downward through the mucous membrane just outside the second bicuspid tooth and hooks up the nerve and draws it out of the osseous canal through the mental foramen. I have quoted thus at length the description of the two operations in order that readers may note accurately the points of difference. The one involves an ugly cicatrix and an extensive destruction of bone, and, as the author states, the necessity of occasionally leaving the wound open to arrest hemorrhage, while the other is neat, leaves no scar, the hemorrhage is easily controlled and it is efficient in its result.

The author devotes sixty pages to the subject of ligation of arteries. In the opening paragraph he insists upon the necessity of minute and accurate anatomical knowledge, which he properly asserts can only be obtained in the dissecting room, but the elaborate illustrations make as clear and plain as is possible by illustration the relations and importance of the various parts concerned. The cuts are well chosen and exhibit only such parts as are necessary to the special ligation considered.

They are not encumbered with confusing minutiæ of minor importance. It is an admirable chapter, and especially valuable to those who cannot each year study anatomy in the dissecting room, but is materially weakened by the multiplicity of unimportant anatomical facts which are mentioned in detail in the text, and which, though important in a text book on anatomy are confusing and unnecessary in a work designed to help the practitioner in preparing for a special work.

On page 742, in referring to fractures into joints, he urges the cautious use of passive movement at the earliest possible moment without giving the indications to guide the practitioner to the proper solution of the time for it, viz.: when little or no pain is produced by the movement and the fragments are united.

The tabular statement he presents of ununited fractures and their treatment, with result, is a most complete and valuable one. It is comprehensive and is indicative of labor and careful research of publications of the last thirty or forty years.

On page 732, in the general consideration of fractures, he states that "fractures which extend through the articular encrust-

ing cartilages seem to have no power to unite." Standing as it does in the text in close relation to other fractures which frequently fail of bony union, we hardly know how to reconcile this statement with the well-known fact that fractures into joints do in the majority of cases unite readily and almost certainly. It is possible, however, that the author intended to refer only to the cartilage which it is well-known proliferates laterally very slightly and with difficulty, leaving very generally at the site of the fracture a depressed groove.

He then gives a table of the special fractures treated in the Pennsylvania Hospital since 1850, numbering 6,485, with the result, so far as known; and to this, in some of his generalizations, he adds those treated at that institution from 1830 to 1850, numbering 2,182, making a total of 8,667 cases. In the treatment of fractures of the femur, he thinks we should be satisfied with half or three-quarters of an inch shortening. This is a sufficient number of cases to justify some generalizations and to indicate clearly to the author the results attending different plans of treatment. He thinks we should be satisfied with half or three-quarters of an inch shortening in union of fractures of the femur. This is probably a safe limit, and is a standard which the author of a surgical treatise can surely defend; but we think that many American surgeons do better than this would indicate, and I am satisfied it is the exception in the hands of some surgeons to have a shortening so great. He dismisses the treatment of these fractures by extension and suspension very briefly, and evidently does not favor the plan, nor does he seem to recognize the fact that there is now a very respectable minority of the profession who advocate this plan of treatment, and who are using with satisfaction Hodgen's suspension splint. The author seems to think that Dr. Hodgen uses the splint only *occasionally*, whereas it is a fact that he uniformly uses it for all fractures of the femur, both in children and adults. It gives a stability and security to the fractured extremities that cannot be attained in any other way, with the comparative freedom and comfort to the patients that it affords. But, whatever may be the author's appreciation of suspension, he certainly has a due regard for the value of extension, for he advocates and practices the use of a fifteen-pound extending weight in the treatment with Buck's method or its modifications.

The volume is a worthy one, and if the second one evinces as much care and as thorough preparation, the work will be valuable as a guide to the practitioner and as a book of reference to the student. It has evidently been the work of years of systematic preparation. The illustrations, numbering 897, are well executed, many of them very important and new. Although needlessly profuse in many instances, they generally add force to the text.

H. H. Mudd.

A PRACTICAL GUIDE TO DISEASES OF THE THROAT.—With one hundred typical illustrations in color and fifty wood engravings designed and executed by the author, Lennox Browne, F. R. C. S. Ed., Senior Surgeon to the Central London Throat and Ear Hospital; Surgeon and Aural Surgeon to the Royal Society of Musicians; Surgeon to the National Training School for Music, etc. 8 vo., pp. xii., 351. London: Baillière, Tindall & Cox, 1878. The same. Philadelphia: Henry C. Lea, 1878.

We remember to have read within the last two or three years, with some degree of interest, articles on subjects connected with the throat, from the pen of Mr. Browne, in several of our medical journals. This, with the knowledge that he was assistant for a number of years to Dr. Mackenzie, in the London Throat Hospital, which afforded him ample opportunity for pursuing the study of the subject of his book, predisposed us to look with great favor upon the work. Another reason for our favorable predisposition toward it, was that it had received the favorable notice of some of the best known critics, and that it came from two houses known to be careful as to the kind of book they undertake to publish. In this instance the publishers have done their part well. The volume has a finished appearance, and if the broad margins, thick paper and large type increases the cost, they also add to its beauty.

After a very careful reading of this book, we are forced, reluctantly, to say, notwithstanding its fine appearance, notwithstanding the very favorable notices it has received, that we are greatly disappointed. We find that that which is true is not new, and that the new facts are very few in number. Certainly, with his opportunities for accumulating new and important truths, and with the long interval between the issue of this book and that of the last English work on the throat, a greater advancement ought to have been shown. The time is past when the profession will be satisfied with a compilation or with a remodeled book containing old ideas. He who would burden us with a new book, must, at least, place in it some material advance in both pathology and treatment, or take the consequence of his book being left on the hands of his publishers.

As this book has had several able defenders, we think that it can stand a little criticism. In the interest of the readers of the JOURNAL, and because we do not want a book unworthy the place commended as a leading authority in a speciality now so generally recognized, we will undertake to show that it is *not* a better "practical guide to the diagnosis and treatment of diseases of the throat," than many books that we have already on our shelves.

If we except the artistic though too highly and too uniformly colored plates, there is but little to commend in the work. According to our method of viewing the subject, the author com-

mits an inconsistency in displaying this "Atlas," without at the same time recording in detail the history of each case illustrated. He says (page 2), "histories of cases in detail have been purposely excluded." Why exclude pen pictures and include lithographic pictures? Was it because the latter make a better showing than the former? The statement that clinical study can only be efficiently pursued in the presence of the patient, applies as well to the presentation of lithographic pictures, for it is certainly as difficult to represent on stone the true appearance of a diseased larynx or pharynx as it is to describe it on paper. If the history of a case is "but rarely of service to the student" it follows for the same reason that the lithographic representation of the same case must be equally as unserviceable to the same student. A truthfully colored picture can be made much more useful to the student if accompanied by an accurately and concisely written history of the case from which it was taken; that is to say, neither picture nor history alone, can give all the information that is desired.

Mr. Browne unaccountably, but intentionally, omits "questions of purely pathological interest." It is difficult for one who has made the study of the diseases of the throat a specialty, to understand what inducement could be employed to prevent him from writing on this most interesting and important subject, for certainly he must have been *prevented* from so doing. Although he omits questions of purely pathological interest, he devotes a chapter to the anatomy of the larynx, but is silent on the anatomy of the pharyngo-nasal cavity. He gives less than nine lines to pharyngeal paralysis; to the uvula he gives eight pages (!). On the first of these eight pages he misplaces the relationship of cause and effect. On this page he makes the relaxed uvula serve "to make the throat peculiarly liable to catarrhal attacks." This may be new, but it is not true.

A few of the inaccuracies are: "formulæ for diseases" (pp. 305, 307, 309, etc.); the first removal of a laryngeal growth is stated to have been done by Lewin (page 248). This is not the case, as it is well known that the first operation of this kind was performed by von Bruns in the case of his own brother in 1860. The inaccuracy of his method of making a diagnosis of conditions giving rise to foul breath is an amusing one. Of course a patient with an ulcerated tonsil might at the same time have an ozœna, but the disagreeable odor from the nostrils could not of itself determine whether it was from a diseased tonsil, the nasal secretions, or of pulmonary origin.

Although the omissions are not remarkable in number, yet they are in kind. In Fig. 54 he represents the lodgment of a pin in the larynx, but no mention is made in the text of foreign bodies in this organ; nor nasal polyse or lupus of the larynx or diseases of the trachea. Another very noticeable omission is, that although he is constantly indebted to others for

the information which he employs in making up his book, he refers but seldom to their opinions, and not infrequently quotes them for the sole purpose of employing them as a foil to his point (pp. 199, 222, 240, 255, 277, 283, 286, 332, etc.).

There are several misstatements also, one of which is: "Absence of thickening is a marked characteristic of chronic laryngitis, to which may be added immunity from ulceration," (p. 199). A three months' student would hardly make such a mistake. Another one is, "the vocal cords have the power of lengthening and contracting;" according to this he would give the bones of the lower extremities "power" to move the body.

Mr. Browne seems to think that the profession has been very greatly deceived as to the effects of the removal of laryngeal growths through the mouth; he says, "that instead of their being innocuous, direct injury of the healthy parts leading to fatal results is by no means of infrequent occurrence;" "however able a laryngoscopist the operator may be, he is, in ninety-nine cases out of a hundred, guided in his knowledge of the exact situation of the growth by previous examination; and when he operates, the larynx spasmodically closing around the instrument as soon as it passes the epiglottis, the growth is caught according to his skill, or, more often, according to his good fortune." Of all the operations that the surgeon is called upon to perform, that for the removal of an intra-laryngeal growth is the *most difficult*; but the man that would, regardless of consequences, or for fear of conveying an impression to his patient that his skill is inadequate to the occasion, press his forceps into the larynx and make a "hit-or miss grab," for a growth is guilty of an act that is *most reprehensible*. There is no wonder that Mr. Browne is disposed to look with disfavor upon the removal of these growths, if he, in ninety-nine times in a hundred, grasps "an arytenoid cartilage or one of the cornicula." (?) We should with him expect to perform tracheotomy after such an operation, and would be well pleased if a fatal result did not follow it. Another one of his assertions (which he calls a proposition) is that "benign growths not infrequently assume a malignant, and even a cancerous character by the irritation produced by attempts at removal." In over four hundred recorded cases of intra-laryngeal operation for the removal of papillomata in three (Mackenzie, Gibb and Rumbold) cases only did malignant degeneration at the site of the tumor follow after the operation, and, of course, it is not certain that in these cases the change in character was due to the operative interference.

On pages 58 and 59 he says "in point of fact, however, very little of the spray enters the larynx. The moment it impinges on the epiglottis, that valve closes tightly against the entrance of so foreign an intruder." On page 63 he contradicts this by saying "the spray may therefore be projected simultaneously, with the act of inspiration." In neither case does he men-

tion the material used. If he had employed a warm non-irritating spray in the first instance, the epiglottis would not have closed tightly, and if in the second a solution of nitrate of silver had been projected into the throat, the simultaneousness of the act with that of inspiration would not have been of any avail; but such indefiniteness is a feature of the book.

The author is certainly behind the times in denouncing tracheotomy in laryngeal phthisis. With the almost incredibly large experience that he claims to have had, he must, from time to time, have seen cases of phthisis in which the main local invasion was in the larynx. Tracheotomy, as recommended by Elsberg, Janeway, Porter and others, relieves, in some instances, dyspnœa, and other sequences of the passage of air through an irritable larynx.

The style of the author is not very classical and it borders on the egotistical. Mention is made to the "author," "writer," "Lennox Browne," etc., etc., over one hundred and twenty times in the three hundred and fifty-one pages. Then we find such expressions as "imperfect bite of artificial teeth." (p. 118); "worked at aural surgery" (p. 47); "lodgment of secretion at a cough-spot" (p. 195); "if there be irritation at any cough-spot," (p. 264). Hemorrhage from the larynx is called hæmoptysis (p. 225), etc.

Let us make comparative quotations from this work and a work on the throat that is now about to have a new edition issued. "In the treatment of acute laryngitis it is essential to make a proper diagnosis at an early date, and to treat it promptly and efficiently, bearing in mind that it is an acute disease, rendered dangerous not from the violence of its action, but on account of the locality which is invaded; and that, for this reason, local treatment takes precedence of general treatment. The laryngoscope is here of the greatest service, both as a means of accurate diagnosis, and as permitting the efficient application of local measures."

"The systematic treatment of inflammation by venesection—the external use of leeches, the internal administration of remedies acting upon the various emunctories—is not applicable here as in inflammation elsewhere, because we dare not always wait for the action of these measures. In mild cases, the external application of leeches, the use of salines, and the inhalation of the steam of warm water, or of astringent solutions, will be of great benefit, and be thoroughly efficient with perfect rest, quiet and silence. In severe cases, especially where there is œdema, early scarification of the parts, by the method to be described in a later part of this volume, will be of immense service. By this procedure the parts are at once disgorged of their blood; the serum is discharged from the tumid swellings; the local symptoms are promptly relieved, and the respiration is rendered efficient for the purposes of the economy in her own efforts at

cure. It is rarely that a second scarification becomes necessary."

"Where scarification is inapplicable from want of appliances, want of practice or other causes, the trachea should be promptly divided, that the lungs may receive a due supply of air to enable the system to pass through the natural stages of the inflammatory process. This operation of tracheotomy must not be delayed too long, but should be performed at the very first moment that the impediment to respiration is recognized as serious. Delayed too long, the blood will have become so poisoned by carbonization that the relief to respiration will not be followed by efficient oxygenation, and the patient will succumb a few hours after having been relieved of the local symptoms. This is the history of many cases who perished after tracheotomy because it had been postponed for a last resort, when, if resorted to early, the probability is that it would have saved life in at least some of the instances."

Now, let the reader carefully compare the above with the following, and let him decide which of the two sets of quotations were written nearly seven years ago, and which has the more lucid instruction concerning the conduction of a case of acute laryngitis.

"The author would advise in all cases the administration of a calomel purge; and when the pulse is full, especially in the case of strong children, would push this drug steadily, both by its internal administration in small and frequent doses, combined with James' and Dover's powders, and by inunction with mercurial ointment. In adults, after the purge, aconite administered in one-drop doses is of great value. Neither emetics, counter-irritants, venous depletion, nor caustic solutions are to be recommended."

"Locally everything should be done to change the conditions most favorable to the causation of the disease. For this purpose the room must be kept at an equable temperature of from 60° to 65°, shielded from draughts and charged with steam. In the case of children, steam from a kettle playing near to their mouths, or wrung out hot flannels in the same position, will aid to this end. In the adult, the frequent inhalation, from an apparatus causing the least effort, of steam combined with volatile ingredients of a soothing or anodyne character, should be constantly employed. Benzoine, chloroform, conium or hop, are the best remedies for this purpose. External poultices and compresses are soothing."

"So soon as, and wherever, œdema is discovered, local scarification with the laryngeal lancet should be employed. There is probably no such severe disease that can be so quickly relieved by a simple local measure as can œdema of the larynx, and the operation is one of really easy performance to a practitioner having but moderate skill in the use of the laryngoscope. The relief to the local distress and the consequent general comfort of the patient is little less than magical."

"When secretion is poured out as the disease advances the process may be favored by mild expectorants. Ice and iced drinks are very agreeable to some patients, while in other cases warm demulcents are preferred. If, in spite of scarification, or failing means for its adoption, the respiration of the patient becomes more feeble and symptoms of blood-poisoning increase, tracheotomy must be performed."

A majority of the readers of the Journal who are unacquainted with the text of either of the works from which the above quotations are taken, would say that the first set given, were taken from the new work, and that the last came from the work written in the spring of 1872, but such is not the case. The first is from Cohen, the last, from the work under review.

These quotations are *a fair exhibit of the comparative value* of the new and old work; and show that Mr. Browne's book is *not* a better "practical guide to the diagnosis and treatment of diseases of the throat" than some that we have had on our shelves for several years. What need is there for a new book, if there is nothing new to record in it; why impose additional expense when there is no additional gain; why take advantage of the anxiety of the student in medicine to become possessed of every new work in the hope of becoming possessed of improved methods and new facts?

Thos. F. Rumbold.

On Fracture of the Femur. By Edward Borck, M. D., Member of the Medical and Chirurgical Faculty of Maryland; Baltimore, Med. Ass.; St. Louis Med. Society; Missouri State Med. Association; Tri-State Med. Society; formerly Asst. Surgeon to West Building Hospital, etc. St. Louis: Geo. O. Rumbold. 1879. Four mo., pp. 52, fourteen illustrations. [For sale by St. Louis Book and News Co.]

This monograph, inscribed to Prof. Gregory, of this city, contains revised articles that appeared in the St. Louis Medical and Surgical Journal, and remarks by Drs. Trader, Broome and Lankford.

Prof. A. P. Lankford, p. 33, says: "Your polite invitation to describe my method of treatment of fracture of the shaft of the femur for a monograph which you are preparing upon the subject, is received. While I have nothing new in principle to offer, I yet comply with pleasure, believing that diversity of opinion amongst teachers and authors of recognized text-books upon so important a subject is alone sufficient reason for your contemplated work. And permit me to add that, in my opinion, your plan is an excellent one, making it, as it will, a true exponent of the opinion and practice of St. Louis practitioners. It will surely entitle you to the thanks of the profession."

Editorial.

The New Year and The Journal.

Again do we wish our readers a Happy New Year. One year ago we promised to exert ourselves to the utmost to maintain, and, if possible, to increase the usefulness of the Journal. That we have not only maintained, but increased its usefulness, has been attested by letters from *hundreds* of our subscribers. Although the labor has been by no means light, yet it has been made pleasant by these expressions of appreciation, and by the long list of names sent us by the friends of the Journal. For these we wish to return our sincere thanks. To our contributors we wish to return thanks. It is with great pleasure that we record the fact that some one or more of the original contributions from each number of the Journal issued, have found their way into the foreign medical journals. We said, one year ago, and again repeat it, that the Journal is ours only as to the risk and labor of conducting it; in all other respects, we hope that the profession will feel that it is theirs, and regard it as an avenue for them to the medical public and a means of individual benefit.

As our readers are aware, on last October we increased the Journal to 112 pages, we now make it 128 pages to supply the demand for more space.

At the time that we undertook this work, we saw that there was room in the West and Southwest for a large medical journal. That room we determined to occupy to the full extent of our ability. We also saw that to do this to the best advantage the Journal must own the office in which it was printed, or else the expense of the publication would soon be greater than the income from the subscribers. An entirely new office was then purchased, and to this stock large additions, from time to time, have been added, so that now the capacity for the amount of work to be accomplished in the Journal office is practically unlimited. With these advantages, aided by a large corps of able and willing co-laborers, we are determined that the Journal shall be second to none in the country.

NEW REMEDIES AND NEW PREPARATIONS.

We intend, in the next issue of the JOURNAL, to open a new department bearing the above title. This department is intended to contain questions, answers and information concerning any of the many new preparations and remedies that are presented to the profession, such as the preparations of cinchonia bark, iron, pepsin, malt, etc. This will be a very useful department if the contributions are short and to the point.

REVIEWS.

Hereafter, reviews will bear the reviewer's full name, this course being more honorable, satisfactory, and now most approved. It also removes all responsibility from the JOURNAL, which is really an avenue only to the profession, and places it where it properly belongs. Even should a review of a book be a very favorable one, a sense of modesty ought not prevent the appearance of the full name of the reviewer; and certainly a sense of manliness would dictate that the full name be appended to an adverse review.

DR. H. CHRISTOPHER.

DR. RUMBOLD:

MY DEAR FRIEND:—On your solicitation I became the Associate Editor of the JOURNAL. A distrust of my fitness for the position made me hesitate; but your partiality gave me encouragement to attempt what might fall to my lot in the association.

Having now accepted a position which necessitates my removal from the city, I deem it right and proper to place in your hands my resignation, that you may have one near you, who will aid you in your arduous enterprise. To me our more intimate relation has been very agreeable, and I realize that the friendship so long existing between us, has been firmly cemented by our mutual labors. I feel no little pride in the reflection that the JOURNAL has now a position before the public, which may well encourage you in the belief that your management has suc-

ceeded in meeting the wants and expectations of the profession, and I sincerely wish that its reputation and prosperity may continue to increase from year to year.

In severing my connection with the JOURNAL I realize how much it is I part from, and this but heightens the regret I feel in taking leave of you. That you may meet with the reward which your disinterested labors so richly merit, I sincerely wish and hope. As ever, very truly yours,

H. CHRISTOPHER, M. D.

ST. LOUIS, Aug. 1st, 1878.

It is with great reluctance and sincere regret that we sever our relation with Dr. Christopher. At the reception of his resignation we could not bring ourselves to the point of accepting it, hoping that circumstances would bring him back to the city from Independence, Mo., where he now resides. There is now no probability that he will return, as he is successfully engaged in educational work, to which he is so well suited. We are pleased to say that the readers of the JOURNAL will now and then have the opportunity of reading his ably written and highly interesting articles. May he meet with appreciative friends.

TRI-STATE AND LINTON DISTRICT MEDICAL SOCIETIES.

The manuscript of these two Societies came too late to be published in this month. Their departments will be opened in the next issue.

We invite attention to the correspondence of Professor E. Andrews, of Chicago. The subject of his letter is one that greatly interests the general profession residing in our country towns and cities, many of whose patients are inveigled into paying a large fee for a trifling operation. Without wishing to prevent any of our readers from addressing Dr. Andrews personally on this subject, we wish them to bear in mind that the pages of the JOURNAL are always an open avenue for special as well as general information.

DEATHS AND RATE OF MORTALITY

Per 1000 Inhabitants, Annually, in the Largest American and Foreign Cities, According to the Latest Returns.

CITIES.	Population	Date of Return.	Deaths from all Causes	Annual Death Rate per 1000	Deaths.	
					Infants under 1 Year of Age.	Persons Aged 60 Y'rs and upwards.
New York	1,086,000	6 weeks ending Nov 30	2,785	22.21	.....	.....
Philadelphia	877,500	5 " " " 30	1,439	16.95	.....	.....
Brooklyn	549,433	6 " " " 30	1,195	18.94	.....	.....
St. Louis	503,000	5 " " " 30	510	10.55	.....	.....
Chicago	460,000	5 " " " 30	669	15.16	.....	.....
Baltimore	355,000	4 " " " 30	449	16.00	.....	.....
Boston	353,000	5 " " " 30	730	20.96	.....	.....
San Francisco, Cal.	300,000	Month of November...	369	14.80	.....	.....
Cincinnati	280,000	2 weeks ending Nov 23	197	18.34	.....	.....
New Orleans	210,000	2 " " " 17	287	35 62	.....	.....
Buffalo	170,000	.....	....	.....	.....	.....
Cleveland	162,000	.....	....	.....	.....	.....
Washington, D. C.	160,000	Month of November...	332	24.43	.....	.....
Pittsburgh	145,000	" " "	210	18.37	.....	.....
Newark	126,000	.....	....	.....	.....	.....
Detroit	125,000	.....	....	.....	.....	.....
Milwaukee, Wis	123,600	.....	....	.....	.....	.....
Richmond Va	79,000	5 weeks ending Nov 6	116	15.70	.....	.....
New Haven, Conn	60,000	Month of November...	87	17.63	.....	.....
Charleston	57,000	4 weeks ending Nov 30	97	28.43	.....	.....
Memphis, Tenn	50,000	.....	....	.....	.....	.....
Mobile	40,000	.....	....	.....	.....	.....
Denver		.....	....	.....	.....	.....
Galveston		.....	....	.....	.....	.....
Indianapolis		.....	....	.....	.....	.....
Springfield, Mass	31,500	.....	....	.....	.....	.....
Nashville, Tenn	27,000	Month of November.	40	14.76	.....	.....
Sacramento	25,000	Month of October	51	23.30	.....	.....
St. Paul, Minn	20,000	Month of November...	33	24.00	.....	.....
London	3,577,303	November 19 to 16.....	1,665	24.30	.....	.....
Paris	1,988,800	" 9 to 15.....	960	25.10	.....	.....
Berlin	1,019,620	October 27 to Nov 2...	516	25.80	.....	.....
Vienna	727,275	November 3 to 9.....	342	24.40	.....	.....
St. Petersburgh	669,741	October 27 to Nov 2 .	415	32.20	.....	.....
Bombay	644,405	" 9 to 15	581	37.00	.....	.....
Glasgow	566,940	November 11 to 16....	281	25.80	.....	.....
Liverpool	532,681	" 10 to 16.....	322	31.50	.....	.....
Naples	475,407	October 15 to 21.....	....	.....	.....	.....
Calcutta	429,535	September 29 to Oct 5	275	33 40	.....	.....
Hamburg (state)	406,104	November 3 to 9.	....	.....	.....	.....
Birmingham	383,117	.....	....	.....	.....	.....
Brussels	175,785	November 10 to 16....	150	20 50	.....	.....
Manchester	360,514	" 10 to 16....	172	21.90	.....	.....
Dublin	314,666	" 10 to 16....	187	31.60	.....	.....
Leeds	304,948	" 10 to 16 ...	163	27.90	.....	.....
Amsterdam	302,266	" 3 to 9. ...	134	23.00	.....	.....
Sheffield	289,537	" 10 to 16. ..	143	25.80	.....	.....
Rome	282,214	October 13 to 19	88	15.80	.....	.....
Breslau	267,000	November 3 to 9.....	130	25.30	.....	.....
Turin	227,846	.....	....	.....	.....	.....
Edinburgh	222,371	.....	....	.....	.....	.....
Alexandria	212,034	October 27 to Nov 2 ..	106	28.70	.....	.....
Dresden	207,845	November 3 to 9.....	88	21.80	.....	.....
Bradford	185,088	" 10 to 16.. .	88	24 80	.....	.....
Salford	170,251	" 10 to 16....	90	27.60	.....	.....
Nottingham	165,267	.....	....	.....	.....	.....
Hull	143,139	November 10 to 16.....	67	24.40	.....	.....
Dundee	142,957	.....	....	.....	.....	.....
Portsmouth	129,461	.....	....	.....	.....	.....
Leicester	121,473	.....	....	.....	.....	.....
Oldham	107,366	November 23 to 30....	61	29.60	.....	.....
Brighton	103,923	" 23 to 30.....	50	25.10	.....	.....

METEOROLOGICAL OBSERVATIONS.

By A. WISLIZENUS, M. D.

The following observations of daily temperature in St. Louis are made with a MAXIMUM and MINIMUM thermometer (of Green, N. Y.). The daily minimum occurs generally in the night, the maximum at p. m. The monthly mean of the daily minima and maxima added and divided by 2, gives quite a reliable mean of the monthly temperature.

THERMOMETER, FAHRENHEIT—NOVEMBER, 1878.

Day of Month	Minimum.	Maximum.	Day of Month.	Minimum.	Maximum.
1	**30.5**	61.5	18	38.0	56.0
2	46.0	61.0	19	43 0	52.5
3	38.0	52 0	20	38.5	57.0
4	39.0	60.0	21	42.5	50.5
5	44.0	61.0	22	36.0	55.5
6	55.0	**73.5**	23	35.5	58.5
7	48.0	53.0	24	40.0	51.5
8	35.0	51.0	25	37 0	45.0
9	37.0	56.5	26	36.0	44.0
10	44.0	18.5	27	33.0	42.0
11	45.0	51.5	28	36.0	47.0
12	37.0	57.5	29	33.0	50.0
13	42.5	56.0	30	36 0	51.5
14	37.5	58.0			
15	40.0	49.0			
16	46.0	50.0	Means	39.8	53.8
17	46.5	52.5	Monthly Mean	46.8	

Quantity of rain, 0 89 inches.

MORTALITY REPORT.---CITY OF ST. LOUIS.

FROM OCT. 26, 1878, TO NOV. 30, 1878, INCLUSIVE.

Yellow Fever	Cholera Infantum. 1	Hydrocephalus and	Apoplexy 7
Measles	Inanition, Want of	Tubercular Men-	Cyanosis and At-
Syphilis, Cong'al.. 1	Breast Milk, etc.27	ingitis 5	electasis 2
Scarlatina 5	Alcoholism 5	Meningitis and En-	Premature and Pre-
Pyæmia 1	Rheumatism and	cephalitis..... 6	ternatural Birth.. 8
Erysipelas..... 1	Gout..... 3	Direct Effect of So-	Surgical Operat'ns.
Diphtheria 29	Cancer 14	lar Heat.....	Deaths by Suicide.. 5
Membranous Croup 20	Phthisis Pulmon 65	All Diseases of the	Deaths by Accid'nt. 18
Whooping Cough.. 1	Bronchitis..... 9	Brain and Ner-	
Typhus Fever....	Pleuritis.....	vous System 48	Total Deaths from
Typhoid Fever ... 8	Septicæmia..... 5	Cirrhosis of Liver	all Causes.....510
Cerebro Spinal Fe. 1	Pneumonia 42	and Hepatitis .. 7	Total Zymotic Dis-
Remittent, Inter-	Heart Diseases....27	Enteritis, Gastro-	eases.....147
mittent, Typho-	Other Diseases of	Enteritis, Peri-	Total Constitution-
Malarial, Con-	Respirt'y Organs21	tonitis, and Gas-	al Diseases.....117
gestive and Sim-	Entero-Colitis 4	tritis.....11	Total Local Dis-
ple Continued	Marasmus—Tabes	Bright's Disease	eases.....200
Fevers.....20	Mesenterica and	and Nephritis ... 3	Total Develop'tal
Puerperal Disea's 1	Scrofula.....30	Other Diseases of	Diseases..... 10
Diarrhœal " 15	Convulsions 24	Urinary Organs.	Deaths by Viol'ce. 24

CHAS. W. FRANCIS, *Commissioner.*

Trommer's Extract of Malt.

The rapidly increasing demand for our IMPROVED EXTRACT OF MALT, during the four years that it has been manufactured and offered to the medical profession in America, justifies the belief that in its production here we are meeting a generally felt want.

Long experience in manufacturing Malt Extract has enabled us to completely overcome the many difficulties attending its manufacture in large quantity; and we positively assure the profession that our Extract of Malt is not only perfectly pure and reliable, but that it will keep for years, in any climate, without fermenting or molding, and that its flavor actually improves by age. Our Extract is guaranteed to equal, in every respect, the best German make, while, by avoiding the expenses of importation, it is afforded at less than half the price of the foreign article.

The Malt from which it is made, is obtained by carefully malting the very best quality of selected Toronto Canada Barley. The Extract is prepared by an improved process, which prevents injury to its properties or flavor by excess of heat **It represents the soluble constituents of Malt and Hops,** viz: Malt Sugar, Dextrine, Diastase, Resin and Bitter of Hops, Phosphates of Lime and Magnesia, and Alkaline Salts.

Attention is invited to the following analysis of this Extract, as given by S. H Douglas, Professor of Chemistry, University of Michigan, Ann Arbor.

TROMMER EXTRACT OF MALT CO:—I enclose herewith my analysis of your Extract of Malt:

Malt Sugar, 46.1; Dextrine, Hop-bitter, Extractive Matter, 23.6; Albuminous Matter (Diastase), 2.469; Ash—Phosphates, 1.712; Alkalies, .377; Water, 25 7 Total, 99.958.

In comparing the above analysis with that of the Extract of Malt of the German Pharmacopœia, as given by Hager, that has been so generally received by the profession, I find it to substantially agree with that article

Yours truly, SILAS H. DOUGLAS,
Prof. of Analytical and Applied Chemistry.

This invaluable preparation is highly recommended by the medical profession, as a most effective therapeutic agent, for the restoration of delicate and exhausted constitutions. It is very nutritious, being rich in both muscle and fat producing materials.

The very large proportion of Diastase renders it most effective in those forms of disease originating in imperfect digestion of the starchy elements of food.

A single dose of the Improved Trommer's Extract of Malt, contains a larger quantity of the active properties of Malt, than a pint of the best ale or porter; and not having undergone fermentation, is absolutely free from alcohol and carbonic acid.

The dose of adults is from a dessert to a tablespoonful three times daily. It is best taken after meals, pure, or mixed with a glass of milk, or in water, wine, or any kind of spirituous liquor. Each bottle contains 1 1-2 lbs of the Extract.

Our preparations of Malt are for sale by druggists generally throughout the United States and Canadas, at the following prices:

EXTRACT OF MALT,	With	Hops	*(Plain)*,		$1.00
"	"	"	*Pyrophosphate of Iron (Ferrated)*..		1.00
"	"	"	*Cod Liver Oil*.....		1.00
"	"	"	*Cod Liver Oil and Iodide of Iron*.....		1.00
"	"	"	*Cod Liver Oil and Phosphorus*.....		1.00
"	"	"	*Hypophosphites*.....		1.50
"	"	"	*Iodides*.....		1.50
"	"	"	*Alteratives*.....		1.50
"	"	"	*Citrate of Iron and Quinia*.....		1.50
"	"	"	*Pepsin*.....		1.50

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TROMMER EXTRACT OF MALT CO.,

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(Rhamnus Purshiana.)

We have a large supply of this valuable remedy, which we know to be genuine, in the form of fluid extract, and are prepared to fill orders for any amount. This drug is undoubtedly one of the most important additions to the Materia Medica and is indicated particularly in habitual constipation, and in dyspeptic complications. It has been proven in repeated trials to be one of the most pleasant and reliable laxatives known to the practitioner. False varieties of this drug are undoubtedly in the market, and we caution our friends against using any of this preparation but what bears our firm name and capsule.

BERBERIS AQUIFOLIUM.

This, perhaps the most valuable of the list of indigenous medicines, was first introduced by us. The profession have long sought in vain for a remedy combining tonic as well as alterative properties. This preparation combines both in a marked degree, and has been proven by repeated trials to be a sure remedy in syphilis, salt rheum, tubercular affections, psoriasis, and all complaints occasioned by a vitiated state of the blood. Physicians who have been disappointed in the results obtained from the use of other preparations, should not condemn the remedy until our extract has been tried, as many spurious varieties—notably the Oregon grape plant—are being extensively sold for the true Berberis Aquifolium.

GRINDELIA ROBUSTA.

This remedy is indicated in asthma, and many practitioners who have used our preparation have found it to be of great value in most of the cases tried. In combination with Yerba Santa it has also been found specially efficacious in bronchial affections. While the general verdict is largely in its favor, still some have been disappointed in its use. In these cases it was probably owing to the fact that the supply of the drug was not genuine. It is a well known fact that many of the varieties of the family bear so close a resemblance to each other that botanists distinguish them only with great difficulty, and the Squarrosa and other varieties are hence often unwittingly substituted for the Robusta. Our own supply is gathered for us under the direction of a competent botanist, and is therefore known to be genuine.

YERBA REUMA.

(Frankenia Grandifolia.)

This is an herbaceous plant, growing near the foot hills of the coast range mountains in California. Its Spanish name implies flowering or flux herb. It has as yet been tested only locally in catarrh, gonorrhœa, leucorrhœa, and catarrhal ophthalmia. The success which it has met with in these complaints justifies us in predicting for it an important place among the new standard remedies. We trust that our professional brethren will favor us with the results of its use in other kindred diseases in which its administration would seem to be indicated.

PENTHORUM SEDOIDES.

This fluid extract has largely come into use as a remedy for catarrh, pharyngitis, catarrhal laryngitis, chronic bronchitis with increased secretion, and in catarrhal affections of the stomach and bowels.

FIVE-FLOWERED GENTIAN.

(Gentiana Quinqueflora.)

Among the many substitutes for quinine, this plant is one of the most valuable. In many cases where quinine and other anti-periodics have proved futile, this remedy has been found very efficacious. In combination with hydrastis, it has been found an excellent tonic in depraved conditions of the digestive apparatus, increasing the biliary secretions and acting as a stimulant to the excretory organs. In combination with gelsemium, and in derangement of the biliary organs in conjunction with podophyllin, it seems to increase the action of those agents.

BOLDO.

(Peumus Boldo)

This is an Alpine evergreen shrub, found upon the Andes in Chili, and is largely used by the natives of that country.

Its therapeutical properties are best seen in blennorrhagia, chronic catarrh of the bladder, hepatic abscesses, and atony of the digestive organs, in all of which diseases it has afforded great benefit. Dr. Chas. A. Zaramba, member of the Sociedad Medica, Santiago de Chila, is enthusiastic in its praise, and pronounces it one of the most important of the recent additions to our materia medica.

Send stamp for our descriptive circular giving full information as regards the therapeutical applications of fifty new and valuable remedies.

Parke, Davis & Co., Detroit, Mich.

NOVEMBER 2, 1878.

Tubercular Peritonitis (?).

DR. P. G. ROBINSON :—I would like to report a case now under my treatment, and to hear the opinions of the members as to its character. It is the case of a young lady 18 years of age, whom I saw two years ago, and in whom, at that time, I diagnosed *chlorosis*. She had all the appearance of chlorosis, intense anæmia and somewhat irregular menstruation, and she was troubled much with palpitation of the heart. I could detect a murmur about the base of the heart. There was no reason for suspecting any organic affection of the heart. The locality of the murmur and its character determined its dependence upon deterioration of the blood, and not upon organic mischief. I gave her tonics of various sorts, iron and strychnia among others. She appeared to be benefitted, but temporarily only. She then passed from under my care, and I did not see her again until recently, when I learned she had been under treatment by another physician, who told me she was suffering from some trouble of the uterus, that she had an anteversion. I went to see the patient, and found her in the condition that I have described.

A prominent feature about the case is distension of the abdomen. The general aspect is one of the most intense anæmia, with some greenish tinting of the skin. She has the same murmur about the base of the heart as formerly. The temperature is steadily elevated, about 103°, perhaps a little more, varying from 102° in the morning, to about 103° in the evening. The skin is somewhat dry, not remarkably so. The pulse is about 110 or 115, and rather weak. Now, on examination, I say, I discovered an appreciable amount of fluid in the peritoneal cavity. There is no general tenderness of the abdomen, but there seems to be a tenderness limited to the hepatic region; and, on careful palpation, I think I made out a slight enlargement of the liver.

The dropsical effusion is a local one. There is no œdema of the lower limbs, nor has there been any enlargement of the veins. There is no indication of any affection of the kidneys, nor, beyond this murmur, of heart trouble, is there any history of ovarian trouble, nor that the enlargement of the abdomen began on one side. Cirrhosis of the liver must be excluded, because the febrile movement and peritoneal effusion have been rather sudden. It seems to me that if this effusion were due to simple hydroæmia and impoverished condition of the blood, there would be a general œdema, as well as an effusion of fluid into the abdominal cavity. I am disposed to consider the possible existence of malignant disease of the peritoneum in this patient.

I have in mind a case of the same kind of a woman, some 35 years of age, who had precisely the same symptoms as these; but we could only make out that there was abdominal dropsy, and that there was probably some peritonitis. In that case there was no such cachectic appearance as in this. My present patient has a waxy aspect. The patient in the City Hospital, to whom I have just referred, had no such cachectic appearance We could only make out a peritonitis and supposed that the dropsical effusion was due to a chronic peritonitis, and considered in that case the possibility of malignant disease. After death we did find that there was chronic inflammation of the peritoneum.

Dr. Bernays:—The Doctor informs us there was no enlargement of any of the lymphatic organs, nor of the spleen. Was the patient of a waxy appearance a year ago?

Dr. Robinson:—She has always been so.

Dr. Bernays:—We have to make a diagnosis, by exclusion, I think, in this case, and even then the facts of the case are hardly enough to warrant a certain diagnosis. It might be a case of leukhæmia. There are three forms of leukhæmia: the splenic, the lymphatic, and the osteogenous. This last form has only been recognized recently. Anatomical changes are found in the marrow and long bones. There is an immense proliferation of white blood corpuscles in the marrow of the bones. When death occurrs by leukhæmia, there is always an effusion into the peritoneal cavity, during the last days or weeks. Very frequently also, œdema of the feet, but, I believe, in most cases, the peritoneal effusion antedates this.

The Doctor positively asserts that there was no enlargement of the lymph glands or spleen. About the pains we cannot determine very easily. There might be slight tenderness on percussion or pressure in the bones. Perhaps, again, the case may be one of the lately recognized disease called *pernicious anæmia*, chronic or acute. The chronic form is found in girls affected for a long period by malarial influences. Possibly the patient may have been subject years ago to fever.

Dr. Robinson:—She had intermittent fever a few years ago

Dr. Bernays:—In the last stages of this pernicious anæmia there is fever, I believe. I have never seen a case of the disease. I have only read of it. But I think in the last stages of pernicious anæmia, there is fever, an increase of temperature in the evening, but the temperature returns to the normal figure in the morning.

Dr. Johnston:—The case reported by Dr. Robinson is one of interest. Supposing the case to be one of chlorotic anæmia, the

question of the origin of this condition is very important though obscure. Is it primarily due to hæmogenic abnormalities? Does it depend upon the condition in which the young girl is receiving her education? Does it ensue upon imperfect digestion? Or does it depend upon some condition of the genital organs? Is it, finally, inheritable? I take it for granted there is a perversion or suspension of the functions of the genital organs. But whether primarily or secondarily, the food is not properly digested, and primary assimilation is defective. There results, consequently, a deficiency of red corpuscles in the blood, and a disproportion between the red and white corpuscles. Hence the chlorotic, anæmic, waxy hue. If nutrition be inadequate, the nervous system must become eventually involved. Where we thus have a deficiency of red corpuscles in the blood with consequent loss of vascular tone, there is no difficulty in understanding, I should think, how an exudation of serum into the abdominal cavity might occur.

Post-hemiplegic Chorea, and Cerebral Automatism.

DR. MOORE:—I was called to a case lately, of rather peculiar character. The patient was a stone-mason, nearly seventy years of age; during the last quarter of a century a free drinker, and for the last ten or twelve years, although not considered a drunkard, drinking entirely too much. Some time since, I was called to see him in a hurry. He had been at his front door and had fallen in some kind of fit. When I got to him, half an hour afterwards, consciousness had returned, and he had recovered from the shock. Since that time his health seemed to improve, he became of fuller habit; his complexion improved, and his weight increased. He had suffered occasionally from rheumatism during fifteen or twenty years. Last night I was called to see him and found that he had lost the power of motion in his right lower limb to a great extent. He was able to walk sometimes unaided, but frequently the loss of power in the leg was so great that he had to be assisted in walking across the room. There was also a loss of power in the right arm, and numbness on the same side of the head. His bowels were constipated, so I prescribed some cathartic pills, which acted freely, and in the morning he said he felt a great deal better, but about 9 A. M. he was taken with an epileptiform convulsion. As he sat in his chair there were convulsive jerkings, the paralyzed side seeming more affected than the other. There was an unintermitted contraction of the affected muscles, but the movements came on in paroxysms. He was entirely conscious, and able to talk to his family for the first hour and a-half after his attack. Just before I got to him he had become unconscious; I gave him chloroform, and in the course of a few minutes convulsions ceased; after a little while I gave him some more; the convulsions did not return, and he went off into a light sleep, which lasted an hour.

His pulse improved, and about an hour after the spasmodic movements had disappeared he opened his eyes, and was able to articulate. I saw him again this afternoon; he had had no return of those spasms; the leg was entirely paralyzed, and voluntary motion in the right arm mostly lost; the loss of sensibility in the side and head still persisted.

During the attack, the muscles were spasmodically affected—very much as in epidemic cholera. The interesting point in the case seems to me to be the preservation of consciousness for about an hour and a-half after the onset, so that he was able to converse with his family, although his suffering was intense. I prescribed nothing for him but the pills mentioned, and afterwards a blister down the spine.

Dr. Bauduy:—As regards the pathology of this case we all know that in persons who indulge in the use of alcohol a hyperæmic condition of the brain is apt to occur. This hyperæmia predisposes to epileptiform attacks, such as the Doctor thinks occurred in his patient. In violent forms of congestion of the brain very sudden epileptiform states are produced; there is no hemorrhage, but there is an intensely congested condition of the entire brain. It is possible that the attack in Dr. Moore's case may have been epileptiform in character, inasmuch as there was some spasmodic twitching of the muscles. The general pathology of such states admits of the superinduction of epileptiform convulsions. I should explain the pain suffered by the patient by referring to the general hæmostatic disposition that exists in persons who are too liberal in their use of alcohol. I have seen the most intense pains ascribed to rheumatism, which are the result of alcoholic empoisonment of the blood. But the most interesting feature of the Doctor's case was the convulsive attack which occurred after the development of the hemiplegia. In the ordinary development of hemiplegia the arm is usually most affected. That is the general rule. There are some exceptional cases where paralysis is more particularly developed in the lower extremity. As regards the particular anatomical state of the encephalon in this case we are still in the dark to a very great extent, though Bastian, in his excellent work on diseases of the brain, states that it is now generally conceded by pathologists that where the paralytic trouble is more particularly developed in the lower extremity, it is due to some lesion in the pons or base of the brain. That is a generally received opinion among pathologists, although it is not stated dogmatically. The most interesting feature of the Doctor's case is the development of the convulsions after the hemiplegia. I will state that the symptoms, taken collectively, certainly correspond to the admirable and classical description of what Charcot calls post hemiplegic chorea. The convulsions were not tetaniform, but consisted in clonic jerkings of the limb. A case of the kind occurred in my practice about fourteen months ago. I was sent for by Dr. A.

F. Barnes, of this city, to see an old gentleman sixty-five or seventy years of age, who had apparently been in perfect health, though there were reasons for suspecting a general atheromatous condition of the arteries. One morning on rising he was attacked with most violent unilateral choreic convulsions, so intense that he was unable to keep still even for a few moments. The limbs would be convulsed with so much violence that his feet would suddenly strike his face, and then, by a powerful contraction of the muscles, be brought down again, striking a chair or the floor with great force. Of course, in that case, the choreic condition antedated the hemiplegic attack. I apprehended there would be a well marked development of hemiplegia on the same side, which really manifested itself after two or three days. As soon as this happened the choreic condition ceased, and he gradually sank into a deep coma and died. Dr. Hodgen and myself dissected the brain together. We found a very general atheromatous degeneration of the arteries with medullary softening. There was a marked similarity of this case to Dr. Moore's, with the exception that the choreic manifestations in my case antedated the development of hemiplegia.

A member reported a case of a similar character, as follows: "The man had never been sick, was seventy-nine years of age and well developed. He had followed his business up to the time he was taken sick in March last, when, after returning from his work at one of the markets, he came home and put his horse up and was found shortly afterwards lying in the street. He was picked up and carried into the house. I was sent for, but did not get there for three quarters of an hour, and found him in a comatose state. He was in violent convulsions of one side of the body, I think the right, while the other was perfectly motionless. I supposed the man would die soon, but gave him bromide of potash and a little chloral. The next day he improved. He would get out of bed, but would fall on almost every attempt to stand. He even continued to improve, and got so much better that he could walk around the house and sit down and talk, all this time being quite rational. In spite of this partial improvement, he had occasional convulsive attacks during a period of three months, eventually becoming very much reduced in flesh and very weak, and at times so much affected that he would fall whenever he attempted to walk. He lingered on for sometime and at last died. This man was perfectly temperate. He had always been healthy, and the convulsions were limited to one side. I saw him during the later period of his illness. It might have been supposed that the patient had a cerebral hemorrhage, but the sequel proved that such was not the case.

DR. HUGHES:—When we consider the very common phenomenon in hemiplegic states of increased reflex excitability of the paralyzed limb in conjunction with complete motor paral-

ysis, so far as voluntary movement is concerned, the existence of these spasmodic movements which have been, as has already been remarked, very properly characterized by Charcot as post-hemiplegic chorea, is easy enough to understand. In considering this epileptiform condition of the brain in connection with the paralytic seizure, it must be borne in mind that a state of absolute unconsciousness is not a necessary accompaniment or a necessary indication of an epileptic condition.

I was once consulted in the case of an individual who, while standing at his desk engaged in writing a note, was taken with one of these epileptic attacks, but, nevertheless, he affixed his signature with as much accuracy as he ever did in his life. It was a case of cerebral automatism, a clear case of automatic function, an habitual function performed seemingly without the knowledge of the individual.

Mr. H. Jackson has, within a year or two, published a number of interesting reports upon cases in the West Riding Asylum illustrative of this matter.

It must be borne in mind that, without most careful observation, one is apt to be quite mistaken in supposing that a paralytic individual is entirely conscious. There are, moreover, varying degrees of consciousness in different epileptics. It is but two weeks, only, since these choreic movements occurred under my own eye, in the case of a Mr. C., while he was seemingly quite conscious, and his consciousness apparently continued unimpaired up to a day or two before his death.

Dr. Bauduy:—I would state in a general way that there can be no doubt as to the choreic character of the manifestations in the case reported by Dr. Moore. The duration of the movements alone would settle the question. Epileptic convulsions last but a short time, while these choreiform spasms occur not only paroxysmally, but last several days. Dr. P. G. Robinson will will remember, that in the case I have detailed, the choreic manifestations lasted several days and prevented the patient from sleeping.

Dr. Moore:—Since we have been discussing this subject, a messenger has called to see me, stating that the patient, every ten or fifteen minutes, has an attack of the convulsive movements of the lower extremities. Having already relieved him by inhalations of chloroform, I directed its continuance if the painful spasms of the right leg should recur.

Dr. Bauduy:—I would like to say a word in regard to this very important question of cerebral automatic action, adverted to by my friend Dr. Hughes. I may refer to a most interesting case, which bears strongly upon this subject. In 1874, I was consulted by the mother of a young girl who was visiting this city, but who was a confirmed epileptic. The young lady had had epileptic seizures since she was two years old. The epilepsy

developed itself in a very peculiar manner in her case, for in her early childhood, she would only have the attacks at definite intervals, rarely having them during the ordinary period of intermission. When she reached the age of puberty, the seizures always limited themselves to the catamenial epochs, so that on the first day of her menstrual discharge she would have one very violent fit, on the second, one or two, on the third, one, etc. The mother would not permit an examination. This young lady had received every possible attention; she had consulted physicians in quite a number of cities, and had even been to Europe for treatment, without any good result. I was obliged to undertake the case, although much disinclined to do so, after the antecedent failures of so many physicians, and in consequence of reading an article in the *American Journal of Insanity*, by Dr. Kitchen, of Utica, N. Y., upon the value of ergot in cases of epilepsy, I prescribed Squibb's fluid extract of ergot, three times a day. I heard some time since that this young lady was cured, and have lately seen her. She states that during the first three months of using the ergot she had only one or two attacks at the catamenial epoch. Since I saw her in 1874, until the present time, she has not had an attack. Questioning her mother more carefully, she told me that the young lady was subject to very peculiar attacks; she stated that in these epileptic attacks, and while unconscious, the young lady would perform actions with perfect correctness of which she would not have the slightest recollection afterwards; she would knit most elaborately; do pieces of handiwork, and when the epileptic fit had passed away she would tell her mother that she knew nothing about it. Her mother would ask her, for example, "Don't you remember on such an occasion, you performed a certain piece of music" (mentioning the company she entertained at some time when she was under the influence of an epileptic wave). It was however a perfect blank to the daughter, yet persons seeing her under this influence would have no intimation of the fact that there was anything the matter.

This case may seem exaggerated, but it is not. The most remarkable case on record of the kind is one which Dr. Hammond refers to. In 1876 a well-known business man left his house, ostensibly going to his usual place of business. All trace of him was lost. The family became alarmed, and put detectives on his track. They did not overtake him, but they heard of his having been at a certain business house, where he conducted himself well; did not seem to be in liquor; answered all questions, and performed business transactions in a very creditable manner. The business men whom he met said they could detect nothing wrong in his behavior. It was subsequently ascertained by the detectives that the gentleman boarded a certain railroad train, and had been put off by the conductor after he had gone a number of miles. He had then walked back to the city, and put up at a prominent hotel. He woke up at the end of eight days

without remembering a solitary fact connected with these eight days' doings. Here we have an individual under this epileptic influence, acting in an automatic way during a term of eight days, entirely without memory, when restored to his normal condition, of anything that had occurred during that time. I will now affirm that this most remarkable case in the literature of epilepsy, presents absolutely nothing which is not paralleled by the case I have myself detailed. I spoke of this matter because during the automatic condition the actions were perfectly normal. As the whole literature and history of the subject shows, epilepsy is intimately connected with cerebral automatism, both before and after its manifestation.

Œsophageal Abscess.

Dr. Bernays:—I wish to report a case that occurred in my practice last week: Some six weeks ago the patient was attacked by what he supposed to be a sore throat. He used a gargle on his own account, but, getting no better, consulted a physician, who ordered a gargle and external applications. The man did not, however, improve, and he had great difficulty in swallowing, which, indeed, was a prominent symptom from the first, with acute pain in the left side of the throat. The swelling continued to increase, until it extended from the angle of the jaw to the clavicle, very hard, prominent and painful. About the third week it was clear that suppuration had occurred. Poultices were applied, the abscess broke, and discharged an immense amount of pus. The discharges continued, and, nevertheless, the man got no better. About a month after this, the patient, meanwhile having consulted another physician, another abscess formed a little higher than the first. After this second abscess had been evacuated, the swelling went down, but the parts remained hard. The connective tissue was infiltrated. There were three fistulous orifices and a little fever at times. This was the condition in which I first saw him. The affection had evidently started in the mucous membrane, so that I was at first considerably at a loss to divine the cause of this obstinate suppuration, but having concluded to examine the sinuous orifices, I passed a probe into the ulcer and felt some hard body. It then struck me that a foreign body might have been swallowed and become fixed in the œsophagus in the neighborhood of the larynx. I accordingly made an incision and extracted a thick broom straw one inch and a quarter long. After its removal the patient grew rapidly well. The man had accidently swallowed the broom straw, which had penetrated the mucous membrane and ulcerated through. There is a case on record of a set of false teeth swallowed during an epileptic attack, impacted in the lower part of the pharynx. I think the teeth ulcerated through. In the case I report no permanent fistula was formed. As the mucous membrane unites the skin opening heals up, in cases of this kind.

November 9th, 1878.

Tubercular Meningitis; Dilatation of the Pulmonary Artery.

Dr. Wm. Porter:—I have a specimen here of considerable interest, but before presenting it to the Society I would like to have the history of the case narrated by Dr. Fischel, who is conversant with it.

Dr. W. E. Fischel:—I did not see the case (a male child of ten months) until three days before its death. I found it comatose. The mother told me that the child had had a very obstinate cough for several weeks. It had been treated with comparative success, by another physician as the cough grew less, and the child was but little troubled until that morning, now about five days ago. On that day the child was taken with convulsions, at intervals of about ten minutes, which passed into violent opisthotonic spasms; during the intervals between the spasms the child was quite unconscious, and not able to swallow. I inquired of the mother whether she had other children who had been troubled in the same way. She told me that four of her children had died very much as this one promised to do. I imagined, therefore that the case might be one of tubercular meningitis. The mother and father, so far as I have heard, are healthy. I could not learn of any tubercular trouble in the family. The child died three days after I saw it, and in making the post mortem with Dr. Porter we found a large cyst in the brain, the brain tissue broken down considerably, with undoubted tubercular deposits; similar deposits existed likewise in other organs of the body, as in the lungs and in some of the glands of the abdomen.

Dr. Porter:—The point that interested me especially, was that on account of a very general infiltration of the lungs, which I determined, early in the life of the patient, there was a manifest obstruction of the pulmonary circulation. I determined this some weeks before death, and particularly, a comparative dulness and deficiency of respiratory murmur all over the left chest, a condition which possibly had continued since birth. On the post mortem table we found the left lung very much infiltrated, so much so that some portions of it sank when thrown in water. We found also a dilatation of the pulmonary artery; in this specimen as I show it, the pulmonary artery is at least two-thirds greater, if not twice as large, as the aorta itself. In the presence of such conditions we might naturally expect to find the foramen ovale patulous, if we remember a suggestion made by Dr. Glasgow at a previous meeting, that a patulous condition of the foramen ovale is generally dependent upon

stenosis of the pulmonary artery. In this case the artery was dilated, owing to the interference with the pulmonary circulation, yet there was no patency of the foramen. The specimen exhibits the features I have mentioned. I do not believe that, as a rule, pulmonary obstruction causes patency of this foramen, though it is infrequently coincident. Hayden, our best clinical authority, says this condition comes from intra-cardiac conditions almost entirely; either there is no valve to close the foramen, or that the valve becomes imperfectly attached to the sides of the foramen, or that the valve is perforated.

Post-hemiplegic Chorea.

Dr. Moore:—I wish to report the progress of the case whose history I detailed at our last meeting, that of an old gentleman who had fallen down stairs in a sudden epileptiform attack. Under the use of chloral, bromide of potassium, and extract of ergot, the spasms of the muscles of the thigh have become less; I have not had to administer any chloroform since the first day. The chloral and bromide of potassium sufficed to control the spasmodic action, but when I mentioned this case last, there was an entire paralysis of the right leg with partial paralysis of the right arm, and numbness of the head. Under the treatment specified, the numbness of the head passed away, but the paralysis of the arm has increased; the patient cannot move his hand at all; two or three days ago he was able to put his hand up to his head, but now he is unable to do so. Singular circumstances connected with the case, are, that an attempt to move his arm will bring on the spasms; and that an effort on his part to move the toes causes pain, and that by taking hold of the feet, spasmodic contractions of the muscles of the thigh are induced. He has suffered also during the week with a great deal of itching of the paralyzed leg. There is apparently an entire loss of sensibility; pinching the leg does not cause pain, but induces spasmodic contraction of the muscles.

Dr. Fairbrother:—The lesion in this case is evidently central, but nevertheless it occurs to me that faradization might be suggested as an additional measure. Many cases like that reported by Dr. Moore have been treated by faradization, and nearly all of them with benefit. Such has also been my experience, lately, in a case of spinal epileptiform spasm, followed by partial paralysis, which was greatly and permanently benefitted by faradization.

Dr. Moore:—I should state also that eight or ten years ago my patient was sick for some time, and fancied he was laboring under disease of the heart; I came to the conclusion that his heart was affected. I imagine the heart trouble may have been of nervous origin.

Dr. Lutz:—Woorara has lately been employed by the Ger-

mans in the treatment of epilepsy. One practitioner has treated eighty cases of epilepsy with this drug. I think it might be worthy of a trial in Dr. Moore's case in combination with the bromide and chloral in pretty large doses.

DR. JOHNSTON :—Various writers on alcohol tell us that it hardens the nervous tissues. * Has the prolonged use of alcohol in this case had such an effect? Has its use affected the nutrition of the spinal cord by inducing sclerosis? It must most assuredly have done so. There is no record of hereditary epilepsy in this case. We know that alcohol is found in the ventricles of the brain of an individual who has been using alcohol excessively, and we know that the fluid contained in the lateral ventricles is in direct communication through the fourth ventricle with the central canal of the spinal cord. Considering the age of the patient and the conditions alluded to, evidently those of malnutrition and impaired capillary circulation, the epileptiform attack can scarcely be credited in this case to hyperæmia of the brain—but rather to cerebral ischæmia, and our practice should accord with this hypothesis.

We know that chloroform produces hyperæmia of the brain and it was in accordance with rational pathology to administer it. If the spasms depended in this old gentlemen upon an impairment of nervous activity, the effect of ergot might be good, but if there existed such a state of active congestion as Dr. Moore seems to have taken for granted by his practice in blistering the spine, I cannot see how ergot would be indicated. If there was exhaustion, or lack of stimulus, then ergot should have been administered; on the other hand, under the hypothesis of an anæmic condition of the nervous system, bromide of potassium was contra-indicated; while if there was congestion of the brain, this drug ought to have been used.

The combination of remedies employed does not seem to have been a happy one; even the chloral has the effects of chloroform, and I am unable to see the propriety of using all these drugs simultaneously. Similar consideration must attach to the use of woorara. It has been employed where there was a lack of nervous power, and defective circulation; but if there be nervous excitement, the use of woorara would be injurious.

DR. GREEN :—Dr. Johnston has stated that ergot is contra-indicated where there is a congestion of the nervous centers. It is generally supposed that ergot acts upon the sympathetic, and through this system of nerves upon muscular fibers of the unstriped kind, and upon the vessels whose muscular fiber is of this variety. Consequently, if there was congestion in the case under consideration, Dr. Moore's practice was correct, and ergot

* Schroeder Van de Kolk used to say, he could tell the brain of a drunkard in the *dark*, by its hardness.—(Com.)

was indicated to antagonize the dilatation of the capillaries. If there was an anæmic state, egot was contra-indicated.

Dr. Johnston:—Ergot induces contraction of the capillary system in a state of congestion. It is essentially a powerful stimulant to the nervous system. Ergot will disgorge the capillary system of the brain, but it has another property, viz., that of stimulating the spinal cord. Where there is a deficiency of uterine action, for example, the administration of a good article of ergot will soon induce increased action of the muscular fibers of the uterus. Ergot acts on the arterial and capillary systems better than any other remedy where we wish to limit the amount of blood passing through the vessels.

Dr. Moore:—In prescribing for this patient, I assumed the existence of congestion of the brain. I do not affirm, however, that my diagnosis as to the pathological condition was correct. I distrust the correctness of my conclusion, for the reason that the evening before he had this attack, constipation existing, I gave him a dose of cathartic pills. They operated very freely. Nevertheless, convulsions came on. Now, if there had been an original congestion of the brain, the operation of the cathartic pills ought to have afforded relief, although next morning he did feel a great deal better. I am not certain, however, that my diagnosis of the pathological condition was correct. The condition may have been an anæmic, rather than a hyperæmic one. What do you think about it, Doctor? (To Dr. Johnston).

Dr. Johnston:—I rather suspect anæmia in this case.

Tumor in a Chicken Formed Around a Pin.

Dr. Williams:—I have a little tumor here which I wish to present. A few days ago, in preparing a chicken for dinner, this tumor was found. In the middle of the tumor a large pin is to be seen, sticking clear through the body of the tumor, the head presenting on one side and the point on the other. The body of the tumor seems to be a chalky deposit. It is apparently almost oblong. The location of the tumor was between the body of the chicken and the upper portion of its thigh. The chicken had evidently swallowed the pin, which had worked its way down through the bowel and out of the abdomen into the position described, the deposit being formed around it subsequently to its migration.

Synopsis of Dr. C. H. Hughes' Paper on Sunstroke.

The prevailing view, in some quarters still, is that sunstroke is essentially a rapid carbonization of the blood. There can be no questioning this as *one* of the essential facts observed in the human system as the result of prolonged high temperature and direct exposure to the sun.

There can be no doubt either that the phenomena of sunstroke may result from high temperature alone without exposure to the sun's rays direct. Observation of this fact by reliable observers has been too often repeated for it to be longer debatable.

This fact has led to the conclusion that insufficient aeration and carbonization of the blood *cause* sunstroke.

But the true *coup de soleil* is not the direct result of carbonization of the blood. Though carbonization usually accompanies or follows the severe and fatal cases, the victim falls prostrate and unconscious, even, or is delirious and insane before the evidences of sanguineous deoxydation appear.

Dr. Morehead[1] "has noted the prominence of ganglionic paralysis, in what he describes as the cardiac variety of heatstroke," those rapidly fatal cases, supposed to take place without premonition, but which are really preceded by suppressed perspiration and hot, dry skin, and Dr. Tilt,[2] from whom I quote, experienced in his own person, phenomena similar to those of heatstroke, only less intense in a Turkish bath, he once took at Damascus.

The livid lips and face, black congested lungs, and turgid, light heart and its supplying vessels are the *post mortem* appearances, or reveal themselves as the patient approaches or has passed into the stage of *articulo mortis*, while the mercury rises when applied to the patient as vitality fails. Life is closed by syncope or asphyxia, but the beginning of death is neither in the heart or lungs, though they play the final part in the tragedy, and death is not far from them.

Solar enervation of the central nervous system manifesting itself first in exhaustion of the sweat nerves and vagus, and next in the vaso-motor and psychic nerve centers, precedes the sequelæ of local stases and is the real disease. Solar stimulation, like electric excitation, manifests itself first in increased action of the sweat glands, lungs and heart. The sweat centers are located as Tuschweiger and Adamkiemiez have shown in the anterior cornua of the cord with a common center in the medulla oblongata.

In polymyelitis anterior along with the motor paralysis you will have paralysis of the sweat nerves. The sweat glands, like the salivary and lachrymal, are especially dependent on nerve stimulation for the performance of their function, and will continue to act after the circulation has ceased, as has been proven by physiological experiment and by observation of persons in extremis. Sweat is not a filtration from the blood-like milk, or bile or urine.

Thermal stimulation is the normal excitation of the sweat glands. Apply a certain degree of heat to any part of the skin surface and if the individual be healthy you will have perspiration at the point where the temperature is raised, not only here

1. Tilt, "Change of Life," p. 143, 3d ed.
2. Ibid.

but reflex transmission along the afferent nerve to the sweat center in the cord and efferently to the corresponding part opposite. The other parts of the body will also be thrown into perspiration later, but the law is that sweating takes place symmetrically.

A hot substance 16° to 20° Fahr. above the natural body heat, applied to any part of the body, will cause the soles of the feet, the arm-pits, etc., to perspire, and a lower atmospheric temperature than this will cause general sweating.

It is thus that nature, ever-conservative of vitality, has provided her own defence against sunstroke. Increased heat excites defensive perspiration, and perspiration by evaporation keeps down surface heat and excludes the heat from without.

The same process takes place from within the trachea, bronchi and lungs. A muco-serous secretion is constantly formed and thrown off with the pulmonary exhalation. These surfaces respond in the same manner as the skin to thermal stimulation.

When sunstroke is impending, the perspiration first fails, preceded by malaise and prostration, and death follows, as the result of thermal exhaustion of the central nervous system beginning with the over-stimulation and resultant prostration of the sweat gland and their governing nerves in the cord and medulla.

The man who sweats well and takes care of his sweating processes, that they are not taxed to the point of exhaustion, does not get sun-stricken. The tropical negro sweats well and his kinky wool and oily skin prevent the too rapid evaporation and drying up of the surface exhalations. With him nature's sentinels are always on duty and are never driven in or captured. The heat enemy does not penetrate his lines; a wall of incessant and inexhaustible evaporation keeps the foe at bay. His pneumogastrics are *in tact* and the heart and lungs respond by increased action to the greater heat irritation and his naturally sluggish circulation is quickened to the demand of changed atmospheric conditions. The healthy white man who wears a hat favorably constructed for cranial evaporation and defence against the direct rays of the sun and two loose, light garments on his body, so that a current of air may circulate about him and the perspiration be kept within normal limits, short of exhaustion and consequent suspension of all action on the part of the sweat nerves, and who drinks liberally of not over cold water, is in little danger of being stricken down by the sun.

It is the damage done to the nervous system beginning primarily at the seat of the sweat centers (though we have abundant symptomatic evidence that other parts of the nervous system are synchronously or consecutively impaired), to which is mainly due the phenomena of sunstroke. When the perspiration ceases, then the wall of normal temperature, which nature erects as a barrier to the invasion of disease, is broken down.

The heat enemy then enters in triumph, marching straight to the cardiac and pulmonic citadels which he overwhelms by carbonization of the blood.

It seems quite impossible that the vagus and cutaneous secretory nerves could be simultaneously paralyzed and the patient become asphyxiated before his skin failed him.

That deficient oxydation and consequent carbonization, is not all there is of sun stroke, is shown in the fact that most of its victims rally on having ice applied to the back of the head and upper part of the spine, from whence the sweat nerves come as well as the par vagum.

When the tone of the nervous system is restored the sequelæ of its enervation vanish.

A stiff constantly blowing breeze, even from the South, by its tonic effect on the nervous system will arrest sunstroke, even though the mercury be up in the nineties.

So will the vigorous use of the fan, or ether externally, and the drinking of plenty of water, while an unresisted or uncounteracted external temperature (long continued) approximating but not above the natural blood heat, may cause death by heat enervation.

The experience of the late sunstroke epidemic in St. Louis confirms all here stated and teaches us same valuable lessons.

We have had hot seasons before with less serious consequences. Why? Because former heated terms have not continued long. The strain on the nervous system, especially that presiding over the cutaneous secretory system, has been less continuous and the vital tone of the organism has been kept up better heretofore by the varying and more tonic atmospheric states.

Every layman of good observing powers who has lived through many heated terms in St. Louis will say that he felt the heat more this year than formerly.

Niemeyer looking at *coup de soleil* through the illuminations of Obernier, got a glimpse of its true pathology, as Moses did of the promised land, but did not go in and possess it. "It has been determined," he says, "that, in one zone at least, the action of the sun's hot rays is not alone sufficient to induce these severe attacks, but that they only occur when individuals are subjected to *great fatigue*, on a very hot day, particularly if at the same time they sweat very little, because they do not drink enough,"[3] notwithstanding he considers the "symptoms of this disease to consist in a paralysis of the the functions of the brain, occurring either suddenly or gradually." (Vol. 11, p. 157.)

The victims of sunstroke were, especially, those whose systems were exhausted by alcoholic and other excesses, by ill nutrition, sickness, and the infirmities of advanced years. Many

[3] It is strange that Niemeyer should reason that the sole cause of their sweating very little was because they did not drink enough, when he recognizes the paralysis of the brain.

were habitués of the Soup House in colder weather, late inmates of the Hospital, frequenters of the Dispensary, and hangers-on about saloons. Among the better class, the incautious, aged and infirm persons, who overestimated their powers of vital resistance and underrated the prostrating potency of intense solar rays.

Now, alcoholic beverages first stimulate the sweat nerves, but, by long and frequent repetition, finally exhaust, not only the power of cutaneous perspiration, but all the powers of the system; and though alcohol is a hydrocarbon and not the proper beverage for hot weather (or any other season), a stimulating draught of brandy, ammonia and ice given to a fainting sunstroke patient, will start the perspiration and cause him to rally. Its oft repetition, however, is not advisable, lest carbonization of the blood be hastened thereby. Few laboring men, who had not been drinking, were found among the stricken. Some of them had been recently sick.

It was interesting to note the number of sunstruck workmen who had on nothing but a shirt. Now, some of these would have escaped had they worn perforated straw hats with wet leaves in them, and linen coats, that there might have been a current of air about their heads and bodies, and a regulation of evaporation so that actual paralysis of the sweat nerves had not occurred.

A vast number of cases of sunstroke or sun prostration never appeared in the papers. These occurred in the families attended by the family physician, and among the feeble people, especially woman debilitated by sedentary lives or recent illness. My own cases were mostly of this kind. The phenomena detailed to me by my patients were, 1st. A failure of perspiration and increase of surface heat, then dizziness, then a feeling of suffocation; and in one extreme case there followed a rise of temperature to 102°.

The temperature never runs up, so far as my observation goes, until after the skin fails to perspire. This year I had no fatal cases, nor have many of the physicians in family practice in the city, so far as I can learn. When, formerly, I have observed fatal cases, the temperature would run up approximating that of the surrounding atmosphere, and this is what we might expect if sunstroke be primarily an enervation and paralysis of the sweat centers, and subsequently of other centers of the cord and brain, for the experiments of Brodie, Bernard, Schiff, Rosenthal, Binz and others, have shown that after section of the cord in the cervical legion, the temperature of an animal will conform to that of the atmosphere about it.

In this connection, as confirmatory of the views here expressed, the case of Peter Wendling, of Lebanon, Pennsylvania, reported by Dr. S. H. Mease, in the *Dental Times*, for 1871, the

entire authenticity of which a recent note from Dr. Mease confirms, is of interest.

Wendling is now (if living,) 45 years of age; and besides being destitute of teeth and of the sense of taste and smell, and without sebaceous glands and hair follicles except in a small portion of his face, "the skin over his entire body is dry, and utterly devoid of sudoriferous glands or ducts." "This latter circumstance," says Dr. Mease, "causes him much suffering during the summer season, more particularly when the weather is warm and the atmosphere is dry. He then for the sake of comfort and perhaps, preservation of life itself—must cover himself with wet clothing and resort to the damp cellar. Here he sleeps, laying on the bare earth."

In hot weather he often suffered with symptoms of asphyxia, which were only relieved by pouring upon him buckets-full of cold water; otherwise he is apparently healthy.

The rational and most successful treatment of heat prostration is simple, and consists in tonic, not depressant, application of cold to the head, spine and peripheral nerves of the skin and buccal mucous membrane more or less continuously, at first, according to body temperature, and later interruptedly, the indications being to lower the temperature and restore the function of the paralyzed sudorific glands.

The body should be first drenched in cold water, then wrapped in a wet sheet and the ice or ether subsequently applied to the head and spine.

If ether be used it should be vigorously fanned away and a time for reaction allowed after each application.

Ice water *per orem* and ice to the buccal mucous membrane and *per rectum*, and the removal of the patient to a cool place, should be relied upon to bring down high internal temperature. In the beginning stimulants, ammonia and whisky, may be sparingly used, but as reaction comes on, and very soon in this case, bromide of potassium and ergot are indicated to avert subsequent cerebro-meningeal or vaso-motor damage, which lead in so many cases to consequences scarcely less serious than fatality.

Dr. Ford:—I think the Doctor's views are substantially sound. I confess that for many years I have entertained similar views with regard to the primary influence of the cutaneous transpiration, upon the origin of acute febrile disorders, and of late, upon the origin and etiology of sunstroke. I look upon the cutaneous function, in this regard, as a very good instance of those reactive processes which I am satisfied constitute the mass of physiological and pathological movements. In other words, the transudation and formation of sweat with its evaporation, is the specialized mode of reaction of the economy against external heat. The Doctor has, of course, adverted to that in his paper. It is by such reactive powers of the system, the old *vis insita* of Haller, what is still meant by the term *vis medicatrix*, that the system is

enabled to counter-balance the effects of external injurious influences, as Herbert Spencer has taken pains to show us. Heat is one of these external agents which affect the animal body most powerfully. The lower orders of animals, especially those living in the water and earth, are not subject to great variations of temperature. Nor is man himself in various parts of the earth, for the average difference between the extremes of summer and winter is hardly more than four degrees at the equator, while this difference rapidly increases as we approach the poles, being often more than a hundred degrees in our latitude. In the experiments of Bernard, dogs subjected to heat in ovens died when their temperature reached 104° F. Their blood was disorganized, and the red corpuscles apparently thrown into a condition very much like that produced by contact with carbonic oxide,—that is, they had lost the power of absorbing or of giving off oxygen. By subjecting rabbits and guinea-pigs to 113° Bernard found that the hepatic functions, notably the biliary secretion, was inordinately stimulated, death ensuing in an hour or so when the temperature was maintained at from 140° to 160° F. The first condition in the etiology of sunstroke is, therefore, a failure of the system to react against unusual heat. Why is this? Why is it that early in the season, the economy will not respond readily by sweating, while, some days or weeks later, everybody sweats readily? In the South I have often been somewhat amused, though deeply interested, by patients telling me (especially new immigrants, natives of Northern climates, Irish, Scotch and Scandinavians): "I do not sweat well, Doctor. Can't you give me something to make me sweat?" It is a fact that early in the summer the system has not got used to sweating; later in the season sweat pours forth readily upon exposure to heat. With regard to the hot weather which was so fatal to many in St. Louis, I noticed that the hot weather came very suddenly upon the cool weather; as a consequence, the skin of the population of St. Louis had not been as yet trained to sweat; so that for the first three or four days the people died like animals in a hot oven. A few days later nature reasserted herself, every man's skin began to respond readily, and the effects of the high temperature were not so fatal. The first effect, therefore, of indisposition or inability of the system to react against heat by sweating, is overheating of the solids and fluids of the body. Hence is induced an overstimulation of those centres which control the vessels, an overstimulation which soon reaches a point at which discharge takes place, a sort of nervous explosion, with immediate loss of vasomotor power. The patient falls in a state of sudden shock, a true exhaustion consequent upon the sudden dissipation and loss of nervous force, and his capillary system and arteries are necessarily relaxed through deficiency of their normal nervous influences. Sunstroke thus consists in a sudden discharge of nerve force from the centers that control the vaso motor system,

when their excitement has risen so high, that the normal inhibitive influences are inadequate to prevent the outburst. The condition of shock in which the patient falls is due, not only to the exhaustion of nervous influence, but to the general gravitation of the blood towards the peritoneal vessels and capillary system everywhere, as a consequence of impaired vasomotor power. A very large quantity of blood is diverted to the abdominal viscera and perhaps the lungs, and thus withdrawn from the heart and brain. Thus sudden shock and more or less prolonged prostration are characteristic phenomena of sunstroke. In many cases there must be a certain amount of alteration of the blood. I have also noticed that there seems to be in almost all cases of sunstroke, a well marked ante-current gastric embarrassment. I have never seen a case where the tongue was not coated before the attack, an evidence of previous impairment of the hepatic functions, which must be held to predispose in some way to this failure of cutaneous action, or to be intimately associated with it.

DR. STEVENS:—I have for some time entertained the idea that sunstroke is not so much dependent upon a high temperature as is generally supposed. My attention was first directed to this point while I was Coroner. The hot season came on, and I expected, of course, that there would be a considerable number of cases of sunstroke. I was surprised to find that although there were excessively hot days, the mercury standing very nearly at a hundred, still there were no cases. I could not understand it; not a case occurred until the season was pretty far advanced, and then on one day I held five inquests for sunstroke. Yet this particular day was not an unusually hot one. I confess myself unable to explain this. I thought that the electrical condition of the atmosphere produced by the high temperature might have had something to do with it, for, of course, on this day the temperature was high, the mercury standing above 100°, but it was not as elevated as it had previously been. We know that heat alone does not generally produce this affection. A very high temperature prevails in the holds of steamers plying up and down the river. Men are at work in that temperature perspiring freely, and when they come up to cool off their clothing is perfectly saturated with perspiration, yet we find that they are strong, hearty, healthy men. I am inclined to think there is some condition of the atmosphere that has not been fully investigated that acts in connection with heat in producing sunstroke. Whether there is an electrical or chemical change of the atmospheric constituents, I do not know. I wish that observations could be made to determine whether, on the days we have such a number of cases, any changes in the electrical or other conditions of the atmosphere could be determined.

DR. BRIGGS:—I have taken the trouble of inspecting the me-

teorological reports which are framed from accurate observation under the authority of the Government with regard to the influence of atmospheric electricity and humidity, upon the etiology of sunstroke. I must say it was impossible for me to find any relation between the number of deaths on certain days, and the degree of electricity in the atmosphere (which was very carefully observed), so that at least on the surface it was impossible to detect any relation between these two orders of facts. It seems to me that Dr. Ford's suggestion that the system had not yet become accustomed to sweating on those days is the most probable hypothesis. I have no knowledge of any facts relative to the theory or therapeutics of sunstroke which combat the very simple notion that it is an important matter to keep the human body at 98.4° F., and that the skin acts like sides of the porous earthenware water vessel, called in the West Indies a *water monkey*, in reducing the temperature of the contents of the vessel itself by evaporation. Conditions which interfere with evaporation interfere very materially with every function of the nervous system. With regard to sweat centers and sweat nerves, spoken of by Dr. Hughes, I have no knowledge of any new investigations. On one occasion, I had an opportunity of observing a body of negroes working in a swamp, at a time when the temperature was not very high, I think about 82° only. It was to be presumed that they would bear such a heat without difficulty, in fact, that they would rather enjoy it. It was in July, but the air of the swamp was exceedingly humid. The negroes suffered severely from the heat, and the condition of sunstroke was produced in several instances. It seems to me that this theory explains such facts very well, and that the facts on the other hand support the theory; for, although the negroes sweated, the humidity of the air prevented evaporation, and therefore prevented the cooling down of the blood to the proper degree.

November 16th, 1878.

Cancerous Growth Involving the Bile Ducts.

Dr. Boutwell:—I have a specimen here obtained from a post mortem which I made for a medical friend in this city. The gall bladder is very much distended, as well as the cystic and hepatic ducts. All this was caused by a cancerous growth at the angle of the pancreas. The cystic duct is involved in the growth. The duct is simply infiltrated, its walls thickened, and its calibre dilated to ten or twelve times its normal size. The hepatic duct is also involved and pressed upon, and like the cystic duct is enlarged at several points. We found a large cystic growth

in the head of the pancreas, and smaller ones distributed throughout the entire length of the organ. The other viscera were healthy, except, of course, the liver, which was atrophied. The patient was a woman about sixty-two years of age. She had been sick as I understood since September 1st. I could not get a history of the case as I did not attend the woman.

Dr. Ford:—I will merely mention in connection with this case, that in the middle of September I was requested by Dr. Y. H. Bond (whose patient she was), to see her. I found her very much jaundiced, but with no fever. She had been sick several months as I understood. On examination the liver was found to extend about six inches below the costal margin, certainly five. It was clearly discernible through the walls of the abdomen, but there were no nodulations, such as might have been felt had the case been one of dissimulated cancer of the liver. At the lower margin of the liver, almost in the iliac fossa, what seemed to be a fluctuating tumor existed, which was at first quite prominent, but on a little manipulation, receded within the abdomen, evidently passing behind the edge of the liver. What this scarcely perceptible and ill defined tumor was, it was not very easy to determine without puncture, which was not practiced. We now know that it was the gall bladder. The existence of hepatic abscess was eliminated from the diagnosis by the facts of the history, and the absence of local and general signs of suppuration. The bowels, if I recollect rightly, were irregular, disposed to constipation. Some bile probably passed into the intestine at that time. There was much prostration and a good deal of emaciation. Under the circumstances we came to the conclusion that it was a cancerous affection of the liver, of what form it was impossible to say. We based that diagnosis very much upon the immense size of the liver, the history of the case and the evident absence of other conditions. There were no nodulations to be felt, it is true, but nodulations do not always exist upon that surface of a cancerous liver which projects below the costal margin, since, as the nodulations may be more limited to one portion of the liver than another, considerable areas of liver tissue may remain unaffected, especially on the surface. But it was principally in view of the non-pyrectic nature of the disease, and the absence of the symptoms of inflammation, of gall stone, and of other causes of jaundice, that we supposed it was a cancerous affection of the liver of some kind involving the bile ducts. The autopsy, which I was invited to make, but was prevented from doing so by pressing engagements, shows us, as Dr. Boutwell has stated, a cancerous, or at least, a sarcomatous growth encroaching upon the duodenum and involving and obstructing the biliary ducts; hence there was a retention of bile and an immense dilatation of the biliary vessels throughout the liver. In these cases of obstruction, the biliary vessels become so much enlarged sometimes, as to give rise to the formation of numerous

retention cysts containing bilious fluid throughout the liver. The bile ducts were enormously enlarged, so that, as I have been informed, on section of the liver, the bile poured out of the organ in great quantity. It was in consequence of the dilatation of the ducts, and the consequent retention of bile that the organ was so much enlarged. Whether the enlargement be due to an accumulation of masses of encephaloid character, or to a retention of bile and infiltration of the whole organ, in either case, a diagnosis of cancer would be valid. I have spoken on a former occasion of the effects of obstruction of the bile ducts in producing changes of the proper hepatic tissue, such as chronic inflammation and atrophy. Here we find the atrophy almost complete, being due to the interstitial pressure of the gorged biliary vessels. I may refer to a case which somewhat illustrates the present one, reported by Dr. Living, of the Middlesex Hospital, in the September (1875) number of the *London Lancet*, where there was almost complete constriction of the common bile duct by enlarged lymphatic glands infiltrated with typical cancerous matter. The liver was olive-colored, and contained bilious cysts in its posterior part. The bile ducts were generally dilated, and the hepatic ducts were distended with bile and dilated to the size of the forefinger. There had been progressive jaundice, with nausea and vomiting. The bowels were constipated. The liver was enlarged and was seen on post mortem to extend to about three fingers breadth below the ribs. The peritoneum, ovaries, and skin around the umbilicus were likewise the seat of cancerous deposit. The gall bladder contained several gall stones. In the case under consideration, the duodenal wall seems to have been involved, and probably some of the lymphatic glands of the neighborhood in common with the substance of the pancreas. The cancerous nature of the case is undoubted and the great enlargement and coincident atrophy of the liver, must be due in all cases very greatly to obstruction to the outflow of bile by pressure of the cancerous nodulations, whether these be seated in the hilus of the liver or within its proper substance. At the same time I may mention that cancer of the gall bladder itself, independently of other structures connected with the biliary functions, is a well recognized affection. Cruveilhier also describes cancer of the biliary ducts.

Dr. Robinson:—I would like to ask if there was any ascites.

Dr. Ford:—Dr. Boatwell states that there was between two and three quarts of fluid in the peritoneal cavity.

Dr. Robinson:—Was that amount of fluid easily recognizable during life, and were there any gastric symptoms?

Dr. Ford:—I only saw the case once, and that was two months ago. When I saw her there was little, if any, effusion into the peritoneal cavity. There was some gastric disturbance,

impairment of digestion and occasional vomiting, but these symptoms were not very prominent. Both Dr. Bond and Dr. Boutwell inform us that there were no gall stones.

Death by Heart-Clot

DR. BARRET:—I present the heart of a woman whom I saw on the 3d inst. Dr. Hodgen saw her with me. She was seven months advanced in gestation, and nineteen years of age. We learned that she had suffered much from nausea, and for several months past with fever that her former medical attendant regarded as malarial. Its well marked periodicity corroborated this opinion. We found her with no appetite, her rest broken by nocturnal febrile paroxysms and by a distressing cough; with a rapid, feeble pulse ranging from 130 to 135, and with hurried respiration. She was emaciated, anæmic, and very weak; indeed so great was the prostration that a safe completion of gestation seemed improbable. Both Dr. Hodgen and myself detected a distinct murmur with the first sound of the heart propagated into the vessels of the neck, but did not examine it critically nor attempt its location. The general condition so strongly favored the supposition of its origin in the blood that we accept that explanation of its production without close scrutiny. Under the application of a cinchonidia-jacket, and 5 gr. doses of quinine every three hours (this was not taken with regularity), the febrile attack was shortened the first day; on the second day it was still shorter and less intense; on the third day there was no fever. The fourth day she was suddenly taken with labor pains, which possibly were induced by the quinine, a hypothesis that seems strengthened by the statement of her mother, that on a previous occasion during her illness, when fully cinchonized, uterine contraction was excited. Labor came on suddenly, no medical attendant being present, though Dr. Hodgen reached the house in a few minutes after the birth of the child. The amount of blood lost did not exceed half a pint, and its extreme coagulability was a notable feature. It was firmly clotted on the pad beneath her in a round mound, with a broad base, and conical apex, in form not unlike a pile of semi-solid fæcal matter. For thirty-six hours after delivery improvement was decided, the pulse fell to 110, respiration was less frequent, there was no apparent fever; she took nourishment freely, retained it, and seemed quite comfortable. At this time I was called in haste, to find her tossing about the bed in the most frantic manner, with an expression of intense agony, and she said with a sense of indescribable anxiety, fear and depression. She called out for air, insisted upon getting out of bed, and was only prevented by force from doing so. The surface of the body was pale, cold and covered with clammy perspiration, the pupils were dilated the respiration was panting, and the pulse too frequent, feeble and irregular to count accurately. The two cardiac-sounds were blended

into one, muffled, indistinct and distant. The respiratory murmur was normal, the uterus firmly contracted, vision undisturbed and the mental faculties clear. Severe pain referred to the umbilical region was an incessant complaint. After about two hours the jactitation subsided somewhat, respiration became less frequent and more labored, and the countenance grew cyanotic. Her demands for air were now more imperative, and she insisted more urgently on being allowed to sit up. Removal to an invalid chair, which permitted a half reclining posture, seemed to afford some relief, and there was a temporary improvement. I left for a few minutes, and was told on my return that the dyspnœa had increased, that she rose up in a great effort to get breath, that a considerable quantity of blood gushed from her mouth, and that she fell back dead. This array of symptoms led me to attribute the fatal result to heart-clot.

In a post mortem made by Dr. Mudd in the presence of Dr. Hodgen and others, no *lesion* was detected except in the heart, which, on examination, presents some unusually large valvular excrescences, characterized by a copious deposit on them of new inflammatory material. A large, firm, white fibrinous clot was also found plugging up the pulmonary artery, and one of similar character, but smaller size, extended into the aorta. Owing to the negligent manner in which the specimen was preserved, these clots are now disintegrated and cannot be seen to advantage. I very much regret this misfortune, because, taken in connection with the history of the case, I regard the clots as the most interesting feature of the specimen, and because they were pronounced by Dr. Hodgen to be the most typical examples of ante-mortem clots he had ever seen.

Dr. Maughs:—After labor, hemorrhage is arrested and prevented both by the contraction of the arteres and by coagulation of the blood in the vessels passing from the uterus to the placenta, now exuviated. Every woman would bleed to death but for this coagulation in the uterine sinuses. At the site of the placenta, therefore, thrombosis always occurs, clots being formed which protrude sensibly into the cavity of the uterus, extending backwards within the vessels until they are bathed by the moving blood. It is easy to comprehend how fragments of such clots may be detached and swept along in the current of the circulation towards the right side of the heart, and thus become impacted in the pulmonary artery or its branches. According to the size of the detached mass, embolism of the lung at the first or second, or any other bifurcations of the pulmonary artery would be produced.

Dr. Hodgen:—I wish to call attention to a point that was overlooked by Dr. Barret in the description of the heart. It is the presence of certain vegetations on the inside of the auricle coresponding to those observed on the mitral valves. They are

pretty abundant. The patient had an endocarditis. As to the position taken by Dr. Maughs, that the heart-clot was due to thrombosis of the pulmonary arteries, determined by the detachment of clots from the uterine veins finding their way up into the heart and floating into the lungs, thus obstructing the pulmonary circulation and damming back into the heart, the observation that I made at the time of the first examination of this specimen (at the post mortem) leads me to believe that the heart-clot was not formed in that way. The clot found was in the right side of the heart, passing into the pulmonary artery and its branches. It was intimately blended with the tendinous cords, and with the columns of flesh found on the inner surface of the right ventricle. In the heart the clot was pearly white, but mingled with red blood corpuscles, and almost like pure fibrin; while in the left side of the heart the blood was a little coagulated and dark red. It was also observed that the clot in the right side lost its pearly whiteness as it passed farther into the pulmonary artery. Now, if the clot had formed first in the small branches of the pulmonary artery, the lung portion of the clot would have been older, firmer and whiter than the heart portion, while the portion of the clot found in the heart would have been mingled with red corpuscles because last formed.

DR. PREWITT:—I venture to say that if Dr. Barret had found that his patient was bleeding, he would have concluded without hesitancy that the symptoms observed were due to loss of blood.

DR. BARRET:—Such was my suspicion when I first arrived.

DR. PREWITT:—We see the symptoms were such as to lead Dr. Barret at once to suspect hemorrhage. Dr. Richardson, of London, has gone so far as to affirm that we can make a diagnosis as to the side of the heart in which the clot has been formed. He claims to have demonstrated the correctness of his diagnosis in a certain case occurring near London, to which he took Mr. Spencer Wells, whom he succeeded in convincing that the clot was on the left side, giving moreover a very unfavorable pregnosis. The patient was almost moribund, but Mr. Richardson said that the clot might possibly be detached, an embolism somewhere thereupon ensuing, with a chance of recovery for the patient. Within a few hours embolism of the femoral artery actually occurred, and the man recovered. Richardson says that on the way home Mr. Spencer Wells told him he was thoroughly convinced of the correctness of his conclusions. We all think that this condition of things is almost necessarily fatal, but Dr. Richardson says he has seen such cases recover under the administration of ammonia every hour, by which he claims the heart clot is dissolved, and the further precipitation of fibrin prevented. Such should be the treatment in cases of this kind. In a low state of the system when the heart

is acting feebly there is a condition of things which favors the formation of a clot, and it is under such circumstances that physicians usually prescribe ammonia, and this is what they should do when heart-clot is suspected, not only for the accepted stimulant power of the remedy, but for the effects which Dr. Richardson claims for it.

Oxytocic Properties of Quinine.

Dr. McPheeters:—Dr. Barret has said that the premature birth was doubtless brought on by the use of quinine. I am very much disposed to doubt the remark. For years, it has been said that quinine is a dangerous remedy during gestation; but I do not believe if given in moderate doses, it has any tendency to produce abortion. When given in large doses, by producing a powerful impression on the nervous system, quinine may have such an effect; but I have been in the habit of giving quinine freely whenever needed, and I do not think it is as apt to produce an abortion, as the condition for which it is itself given. According to Dr. Barret's statement, the patient took but fifteen grains a day. I doubt very much, whether such an amount of the drug can be charged with the induction of the premature labor. The condition of the patient, I think, had more to do with the production of abortion than the quinine given. I wish to enter a protest against the idea that quinine given in such doses is competent to produce abortion.

Dr. Barret:—I said fifteen grains a day; I should have said five grains every three hours; that would be about thirty or forty grains a day.

Dr. Hughes:—Mr. Chairman, I have very little doubt about the power of quinine in what are called sedative doses to produce uterine contraction. Several cases have come under my observation which have led me to that conclusion. The last case, —one which impressed me very thoroughly on the subject, was of my own wife. She was suffering with acute pneumonia; the temperature running up to 108°, when not under the influence of quinine. Upon consultation with Dr. Ellsworth Smith, it was determined to use large doses of quinine—twelve grain doses every four hours, as long as the fever persisted. The oxytocic property of quinine was canvassed before administering it, but we determed to take the chances. The quinine always brought down the temperature which attained 108°, and once, 110°, its average being generally 106° Fahr.; it was imperative, therefore to give these large doses The result was what we feared; I could see no other cause for the uterine contraction which ensued, because this could not have been attributable to the febrile state as the temperature was materially reduced upon the administration of the quinine, falling to 100° Fahr. That was the opinion of Drs. Ellsworth Smith and Spiegelhalter, who saw the case frequently; they both attributed the uterine action to the quinine. This was

the fourth or fifth case in my experience, where quinine was, I think, the cause of uterine contraction.

DR. ROBINSON:—I should like to ask Dr. Hughes why he should think that the quinine and not the pneumonia produced the abortion? The question is one, it seems to me, where positive evidence or apparently positive evidence, is much less valuable than negative. I agree with my friend, Dr. McPheeters. I have never seen any such influence of quinine upon the gravid womb, and I have given quinine in large doses—adequate to combat severe attacks of intermittent and remittent fever, to at least twenty gravid women in the last three years. In a very violent case of bilous remittent fever, some three years ago, which I saw in consultation with my friend, Dr. Bauduy, we were obliged to give very large doses of quinine to a lady in the seventh month of pregnancy, without any manifestation whatsoever of this oxytoxic power. Of course with our present suspicions with regard to this effect of quinine, I would administer the drug only when decidedly indicated. If a high grade of fever is allowed to continue in a pregnant woman, abortion or miscarriage is very apt to take place; in such cases we must choose between the two horns of the dilemma. I should imagine that a febrile state such as Dr. Hughes has described, involving so great a disturbance of the circulation, would be entitled to as much credit in producing the abortion which occurred, as the quinine given for the purpose of abating it.

DR. BARRET:—I called attention to the quinine administered in this case, Mr. President, because, while I am not positive, myself, as to the oxytocic property of quinine, I thought this was a case that might seem to indicate that it had this property. In this case the malarial symptoms were annulled, the skin became moist, and the general condition was much improved. Nevertheless, uterine contraction supervened, so that it seems to me the quinine must be credited with producing the uterine contraction.

DR. A. GREEN:—I think it my duty to say a word in favor of the best friend of the physician, quinine. In my whole practice I cannot recall a single case where quinine has brought on abortion, but I am sure I know of many cases where intermittent fever has done so. We know that where the temperature runs very high, abortion is exceedingly apt to occur, as in small-pox or typhoid fever. In Dr. Barret's case, the high temperature of 106°F. probably destroyed the fœtus, whose death lead to its expulsion.

DR. MAUGHS:—I wish to say a word on this subject, for I think I may justly claim as large an experience in this direction as any member of this Society. I was born and reared in a malarial district. In 1844 I was a medical student in a malarial

region, when the entire country was prostrated with congestive fever. My preceptor was sick, and I was compelled to visit his patients. Quinine had just come into use, and I found it an admirable remedy. Though but a medical student, I knew that to cure chills and fever the only thing necessary was quinine, and I gave quinine without stint. Under its use several cases of miscarriage and abortion occurred, as I think, distinctly owing to the peculiar action of the drug upon the uterine fiber. Quinine produces a powerful impression upon the nervous system which may produce abortion. I give it very cautiously when I am obliged to do so. Knowing its oxytocic effect, I always combine it with morphia. I think, by acting thus, we can always prevent abortion. I have no more doubt, after an experience of thirty years, of the oxytocic effect of quinine than of ergot. Some women, of course, may not abort under its influence, but women who easily abort would very certainly do so under the influence of large doses of quinine.

Dr. McPheeters:—The point that I wish to insist upon is that the use of quinine, as a rule, will not produce abortion, but not that the injudicious use of it might not do so. I admit that quinine given in large doses, like any other remedy which produces a powerful influence upon the nervous system, might possibly produce abortion. It is a popular opinion that quinine does produce abortion, but, in an experience of thirty-seven or thirty-eight years, I have given it whenever I thought it was necessary; and I have never seen a case of abortion produced by it when used in moderation. I have known abortion to be produced by intermittent fever; and it is not to be unhesitatingly assumed that, in Dr. Maughs' cases, the quinine, and not the fever, produced the abortions. Many women abort very easily, and we know that in nearly all eruptive fevers abortion is frequent. I consider the doses spoken of by Dr. Barret as very large doses, but I am positive in my belief that, in moderate doses, quinine will not act upon the uterus. I have very often given it in considerable doses for neuralgia, during gestation, accompanied with morphia, which certainly does modify its action to some extent. I have sometimes given five grains, associated with $\frac{1}{6}$ or $\frac{1}{5}$ gr. morphia, but I do not, under ordinary circumstances, give pregnant women as much as five grains at a dose.

Dr. J. M. Scott:—I agree with Drs. McPheeters and Robinson with regard to the use of quinine. I have sometimes heard it said that quinine was an abortive, but I have during the last summer treated several ladies for severe intermittent fever who were pregnant. I gave them all quinine, but, I confess, not in the heroic doses that some of my professional brethren are in the habit of using. Five grains is my maximum dose in these cases, and three grains my usual dose. I have never hesitated in giving quinine in such moderate doses to pregnant women, although

many authorities claim that it is an abortive. Of course, in very large doses I can readily understand that it is so.

Dr. Hughes:—I have seen cases in which ten gr. doses produced uterine contraction, which remitted when the quinine was stopped, to re-appear again upon resumption of the remedy. I practiced medicine, Mr. Chairman, in the country once myself, and in 1859 I observed facts which convinced me that quinine had the effects I have claimed for it upon the uterine fiber when administered in sedative doses.

Dr. McPheeters:—That is the very point that I made.

Dr. Maughs:—And that is the point that I make also, viz: that sedative doses of quinine are apt to produce uterine contraction. It has been said here to-night that a febrile temperature of 106° would kill the fœtus. In the case which came last under my observation the fœtus was not born dead. I am not sure that I have seen the affirmation distinctly put forth by any reputable author that quinine is an oxytocic, but I am quite confident there is a general current of opinion in that direction running through the literature of medicine. With regard to the relation of the pneumonia in the case cited by Dr. Hughes, to the abortion which ensued, I would ask if the increase of heat caused by the pneumonia, brought about the expulsion of the fœtus, why did not that expulsion take place earlier in the progress of disease than the end of the fifth week of the pneumonia? So, on the other hand, in malarial fevers, why is it that the expulsion of the fœtus does not take place until the physician appears and administers his quinine? When a patient continues to have her intermittent during the whole autumn without showing any disposition towards abortion, and then after sending for her physician and taking his quinine, has a miscarriage within a week, is it not logical to conclude that the miscarriage is due to the quinine taken? I have never seen it maintained that quinine invariably induces contraction in the pregnant uterus. I believe myself that this effect of quinine is exceptional, but that it does occur, I have no doubt, which it is well, however to bear in mind, so that when a patient under the influence of quinine tells the physician that she feels uterine contraction, it is best to suspend the administration of the drug, or at least to diminish the dose given.

Dr. Barret:—I wish to call attention to the fact that if quinine produces contraction of the uterus, that the combination of opium with it will not always prevent its doing so, for opium was administered with the quinine in the case I have reported.

Dr. Steele:—My experience is somewhat like that of Dr. Hughes. A lady in my family who was enceinte, had chills and fever, and I administered ten grains of quinine to her—no more.

The intermittent was jugulated, but within thirty-six hours this lady miscarried of a four or five months' fœtus. I blamed myself very much, and it is with extreme care that I now give quinine in such cases.

Dr. Roland:—I feel it my duty to give my testimony in this matter. Having practiced medicine for a long time in fever districts I have, as a matter of course, given quinine in large doses. In intermittent fever, my custom has been to give eighteen or twenty grains to forestall the paroxysm, and I have often known such doses produce uterine contraction, and, in a few instances, actual abortion. These twenty gr. doses, divided into doses of three to five grains, was all I gave. I have repeatedly known ladies to take quinine without consulting me with the effect of inducing uterine contraction, which, on being sent for, I have treated like any other case of threatened abortion. I have known very few actual abortions produced by quinine, but I have known a number of instances, where I am confident, that without the use of morphia or an opiate, abortion would have been accomplished. In one case a lady took quinine of her own accord in five grain doses, and it brought on uterine contraction, or at least uterine contraction declared itself; I was called in, and administered morphia freely, put her to bed, and kept her quiet, and three months afterward delivered her of a healthy child. I simply wish to say that if quinine has no oxytocic effect, I have been laboring under a very great mistake.

November 23d, 1878.

Acute Nephritis.

Dr. P. G. Robinson:—I beg leave to show a specimen of urine from a case of acute nephritis occurring in a little child who had scarlet fever about three weeks ago, and has been taken during the last day or two with acute nephritis. What I here present was voided about two hours since. There are no dropsical manifestations thus far, nor œdema of the face or feet. The child has a high fever, and is dangerously sick. The urine, as will be seen, is remarkably dark—almost black—the dirtiest-looking urine I ever saw in a case of this kind. It is almost completely free from urinous odor, smelling somewhat like beef tea. After standing but a few moments it lets fall a very copious black sediment. This urine is highly albuminous, and, as shown by the microscope, contains a great quantity of altered blood cells, with crystals of urate of soda and ammonia, and numerous epithelia cells and casts.

Cystoid Diverticulum from the Pericardium.

DR. BAUDUY:—I have an interesting specimen to present, derived from a post mortem made by Dr. Prewitt a few hours after death in the case of a patient of mine that died of heart disease. Cadaveric rigidity was well marked. There was general anasarca; diffused ecchymotic patches were scattered over the skin; the abdomen was tympanitic in the umbilical region and much distended. A considerable quantity of fluid was found in each pleural cavity, but its quantity was greatest on the right side. The lung was firmly adherent on the right side to the diaphragm. The pericardium contained several ounces of fluid. Connected with the right inferior surface of the pericardium was a cyst or pedunculated sac containing, by measurement, two ounces of fluid, which could be expressed through a small opening into the pericardial cavity, with which the interior of the sac or cyst was thus continuous. The lungs were œdematous, congested, and highly pigmented. The heart was enormously enlarged. On its outer surface some old fibrous bands existed, the result of previous inflammation. A voluminous black clot distended the right ventricle, and the auriculo-ventricular opening was very much enlarged, admitting of the passage of three fingers through it. A clot was also found passing from the right ventricle into the pulmonary artery, and some three or four inches beyond the bifurcation of that vessel. A blood clot likewise distended the left ventricle. The aortic valves were affected by atheromatous degeneration, and we found patches of atheroma about the commencement of the aorta, where some old ulcerations and one or two little vegetations (unfortunately broken off from the specimen) also existed. The liver was markedly granular. The cortical substance of both kidneys was somewhat atrophied. Microscopic examination showed hyaline casts in the urine during life.

I have searched the literature on the subject and have been unable to find any similar example of a cystoid growth connected with the pericardium. Rokitansky affirms that cysts are found in connection with nearly all the serous membranes of the body except the pericardium. After very careful examination of his work, I have only been able to find the following allusion explanatory of the features of the specimen presented. Under caption, "Deviation of serous sacs from their natural size and form," he says: "The principle deviations in these particulars are those in which the serous sacs are enlarged, a change to which their great sensibility renders them liable. In enlargements of this kind the sac may be distended equally in all directions, and thus preserve its natural form; or, being bound down in some situations by fibrous membranes, aponeurosis, muscular coverings, etc. It may yield at some *circumscribed* spot and give rise to a hernial protrusion or diverticulum which com-

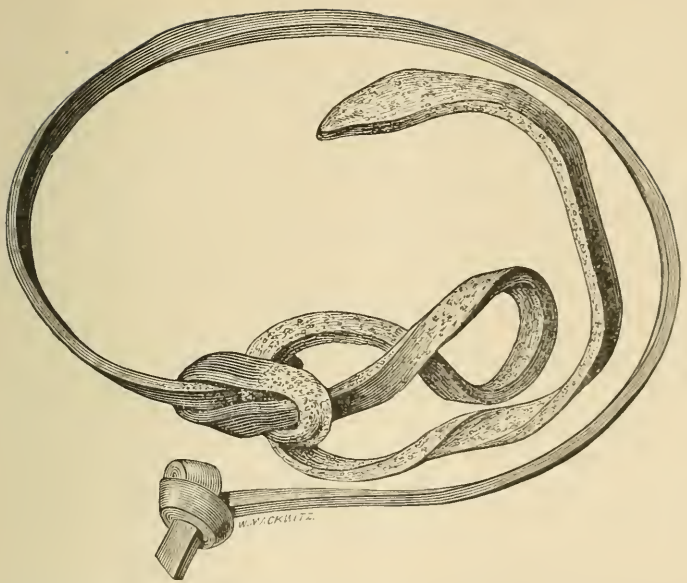
municates with the general cavity of the sac by a constricted neck."

Dr. Hodgen:—The Doctor informs us that there are evidences of old pericarditis in this case. The opening through the pericardium is about the size of a small cedar pencil. It is probable that there was softening at that point during the existence of the inflammation, and that the pericardium being distended by the serous effusion; and the fibrous layer of the pericardium giving way, the connective tissue binding the pericardium to the pleura was distended by the fluid from the pericardial sac, and the pericardial pleura thus formed a sac large enough to hold two ounces of fluid. It will be observed in looking at the specimen, that the sac itself does not gather to a point at the opening of the pericardium—(that is looking at it from the pleural surface) but that it is attached in a line running forward two inches; connective tissue binds the attached line of the pleural covering to the fibrous portion of the pericardium in a such a way as to make the connection between the two much more extensive than the perforation. It is probable then that there was softening of a limited portion of the pericardium and the distension by the pericardial fluid pushed the connective tissue before it and that this carried the pleura in front of it, so that the pleura forms the outer layer of the sac. I understand the diverticula sometimes found in the intestines are due to ulceration of the mucous and muscular coats. And the distension has carried the serous membrane and connective tissue outward, thus forming the pouches.

Cardiac Dropsy.

Dr. Montgomery:—Dr. Bauduy's case reminds me of a patient of mine who has been under my care occasionally during the past twelve years. She is now over forty years of age, has always been very delicate, but not seriously sick before her twenty-first year. At that time she had a severe attack of illness with pain in the right side, fever, copious sweatings, anorexia, and palpitation of the heart, which, however, was not very marked. The right side became much swollen and painful, and she was confined to bed about two months. Finally the swelling suddenly receded, and she passed a great quantity of purulent matter by stool. Before this occurred she had been occasionally affected with obstinate constipation alternating with dysentery. After the subsidence of the swelling and the purulent discharge she seemed to be completely relieved, and remained tolerably well for ten years, though always delicate, having meanwhile married.

About twelve years ago I first saw her, shortly after her marriage. She was then pregnant. She complained of what she called fluttering of the heart, and she could not go up stairs ex-



Full-size illustration of leather thong drawn through (knotted) the urethra of a male; described by Dr. Hodgen on page 246.

cept at a very slow gait. The liver was distinctly enlarged, and she had some hemorrhoids. As formerly, she was troubled with occasional dysentery, her bowels being usually extremely torpid. Her color was icteroid, her appetite poor and thirst intense. Almost every five or six months since I first saw her she complains of soreness of the side; the liver then became much swollen, and the heart's action very irregular, showing mitral insufficiency. Her pulse in these attacks beat about 100, omitting to count the intermissions which take place at about every fourth beat. More lately her attacks have become aggravated and more frequent; just now she has passed through an unusually severe one. About eighteen months ago dropsical effusion first appeared in the lower extremity from the ankle to the knee. This occurred on two or three occasions, but yielded readily enough to digitalis and acetate of potassa, with hyoscyamus and extract of jalap. After some time I gave her iron. Passing through an attack of this kind, she got on pretty well, and was able to attend to her duties for five or six months again. But in the last two attacks the dropsical effusion has been still more extensive, the swelling extending from the feet to the buttocks. Finally effusion began to manifest itself in the abdomen, and for a time the swelling of the lower part of the body was so great that I thought I would have to puncture the legs. But I have thus far always succeeded in getting rid of the serous effusion by medicine, viz: extract of jalap and hyoscyamus, sometimes combined with a very little calomel, following up these drugs with a diuretic mixture containing digitalis and acetate of potash. Although the kidneys seemed to act but little, as long as the anasarca lasted, I never could discover any albumen in the urine, except when the urine was unusually scanty.

In her last attack the heart's action was so much disturbed that she could not lie in any position except on her back, with the shoulders very much elevated. Her color from being icteroid became almost like bronze, her hands and feet perfectly livid. A curious feature in the case during the last twelve months is the appearance of very dark, almost black, streaks all over her body, as if made with a paint brush charged with brownish black paint, in rectangular and serpentine lines. Really, I have never seen anything like this in my life. Her skin looks almost like that of a leopard or a zebra. She manifests, also, a very remarkable tolerance for digitalis, which acts charmingly. As soon as the heart's action is improved I discontinue its use, but the heart is greatly enfeebled, and its action is more or less unnatural at all times, and her breathing is always short. Although each new attack seems to be worse than the previous one, I am pretty sure she may live for some time yet. Really, seeing her in one of these attacks, one would not think it possible she could live many days in the presence of such grave symptoms, the heart's action so irregular, and the

pulse so feeble, the extremities so cold and livid, the skin of the color of bronze; and these conditions, with the occasional dysentery, all portending a proximate fatal termination of the case.

Dr. Johnston:—What quantity of digitalis did you give, Doctor?

Dr. Montgomery:—About half a teaspoonful of the tincture, four times in the twenty-four hours.

Dr. Boisliniere:—I would like Dr. Bauduy to tell us something of the history of his case.

Dr. Bauduy:—The first conspicuous symptoms was progressive œdema about the ankles, followed by general anasarca. Dr. Robinson, who was called into consultation in the case, agreed with me as to the existence of a well-marked double murmur, systolic and diastolic, heard most distinctly in the neighborhood of the aortic opening. The diagnosis was, therefore, made of aortic disease. There was evidence of enlargement of the heart, and, of course, as the case progressed, of the presence of serum in some of the serous cavities. The lungs became, also, very much conjested, and sub-crepitant râles were heard at the base of both lungs. The patient complained of a sense of imminent suffocation, gasping for breath; the skin was cold and clammy; the pulse accelerated. This condition was almost entirely relieved by the free administration of stimulants. As the disease advanced, the dropsical symptoms became more developed, and the cardiac cachexia more and more prominent. During the last portion of the patient's life, it became almost impossible for him to sleep. I do not suppose, with the exception of snatches of sleep, of ten or fifteen minutes duration at a time, that he slept at all. Some three or four hours before the patient died, I was called to draw off his water. On passing a catheter, a very free hemorrhage ensued. As I had passed the catheter very carefully, and have never had an accident in doing so for the last fifteen years, I was very much surprised to see this hemorrhage. I supposed I might have made a false passage. Feeling much annoyed, I asked my friend, Dr. Prewitt, to see the case with me, who, after examination, declared himself of the opinion that no accident to the urethra of any kind had occurred. While Dr. Prewitt was passing the catheter, my mind was relieved by seeing the patient spit blood in considerable quantity. Here, then, was a marked hæmoptysis, showing, in all probability, that the urethral hemorrhage was due to the condition of the blood and universal passive congestion, which characterizes the cardiac cachexia, and that, very probably, some slight abrasion of the urethral mucous membrane was the source of the blood, by lacerating some of the over-burdoned capillaries, whose rupture was evidently the cause of the hemorrhage from the lungs, in the presence of a similar capillary turgescence. The main

features, therefore of this case, were characteristically those of cardiac dropsy. I was somewhat surprised, as were also my friends, Drs. Robinson and Prewitt, I think, to find so little kidney disease, although hyaline casts had been found in the urine. A small cyst was found connected with the left kidney, and the cortical substance of the kidneys was somewhat atrophied.

Cancer of the Stomach and Liver.

DR. LUTZ :—I here present some specimens taken from the body of a patient who came under my observation in August last, 37 years of age. Both of his parents died at an advanced age. His brother and sister are still alive and in good health. He had been drinking too much for some years back, and when first seen was somewhat dyspeptic. His dyspepsia, as the patient thought, yielded to ordinary treatment. I heard nothing more of him until about ten days ago. When I saw him again he was very much emaciated, complaining of constant vomiting, obstinate constipation and great flatulency. As he lay in bed on his back, a tumor was plainly perceptible in the epigastric region large enough to fill the hand laid over it, apparently about the size of an orange. On close examination, however, very distinct fluctuation was detected, so much so that an abscess was suspected, and the propriety of making a tentative aspiration discussed. This, however, was not done, and the patient died yesterday evening. On opening the abdomen after death, it was found that the tumor was covered by the left lobe of the liver. This was very much thinned where it overlay the tumor, being, on an average, only one-eighth of an inch thick. On incision of the tumor a large quantity of cheesy matter escaped. Several similar cavities were found on the anterior portion of the stomach, but hidden in such a way under the margin of the liver that not much more than usual dullness during life about the margin of the ribs was observable. The liver did not extend to any considerable distance below the costal margin. Three cavities of this kind were found intervening between the lower surface of the liver and the anterior portion of the stomach, and binding them to each other. The stomach was pressed over to the left, its cardiac portion being driven into the left hypocondrium, crowding the spleen backwards and upwards. On laying open the stomach along its lesser curvature, the cancer, which was evidently primary, was found at its upper and anterior portion in the pyloric extremity of the stomach. The enormous cancer which is seen in the liver is doubtless secondary, as is most usual in such cases.

A Large Knot Drawn Through the Male Urethra.

Dr. Hodgen then showed a leather thong, taken from a man's bladder, and read the following communication:

Silver Reef, Washington Co., Utah,
November 6th, 1878.

Dr. Hodgen, St. Louis.

Dear Sir:—I send you by mail a registered package, containing quite a curiosity, in the shape of a leather thong. This piece of leather I extracted from a man's bladder, some five or six days ago, and I send it to you not only on account of its being a surgical curiosity, but to show to how great a degree the urethra may be dilated without laceration.

The patient, a man of forty-five, presented himself with the end of the string, bearing the small single knot hanging out of the penis an inch or so, and stated that he had been in that condition ten days. An examination showed that the string had passed into the bladder, and was either coiled up, knotted or kinked. Not wishing to cut into the bladder, except as a last resort (I am mining here, and have nothing in the way of instruments but a pocket case), I chloroformed the man to see if a little traction on the string, aided by manipulation through the rectum, would not alter the position of the coils or kinks so as to allow the string to be pulled out as it had been introduced. I took the precaution to inject sweet oil and force it down as far as possible. Finding that by the use of considerable force, I could feel the body moving forward, I determined to extract it in that manner, intending if it should become imperative or should lacerate the membranous portion of the urethra to cut down in the mesial line and extract through the incision.

To make a long story short, after a good deal of trouble, and after enlarging the meatus, by incision, "the baby was born" just as you see it.

It looks like a rough thing to drag a bull's hide from out a man's bladder, but the man is up and about his business. I wish to state that the man was of the opinion that the string was tangled up in the bladder.

Dr. Cooper and Mr. Wagner were present and assisted.

Yours truly, Junius Terry, M. D.

The string is of thick belt leather. At the widest point it measures $\frac{5}{16}$ of an inch, is 22 inches long, and the thickest part of the knot measures nearly two inches in circumference. In drying, the knot is no doubt larger than when drawn from the urethra. In examining the knot, I find at the largest point there are six thicknesses of the leather thong.

The Doctor remarked upon the variety of things found in the bladder, as pieces of slate pencil, lead pencils, hair pins,

darning needles, pieces of lead, stems of tobacco pipes, pen knives, etc., etc. A female physician related to me a case in which a stone had formed on the bladder side of a button which had been used to close a vesico vaginal fistula. She made an instrument like the studs we wear on our shirts, separated the buttons by a space sufficient to correspond with the thickness of the septum, and slipped one button through the opening in the vagina into the bladder, and thus embraced the two surfaces of the partition under the button. The Doctor said that the patient would have gone on very well, if she (the Doctor) had only thought and been careful to have the water which the patient drank filtered or distilled, so that the sand would not collect on the vesical side of the button. The string itself bears indisputable evidence of having been in the bladder. Any one will see evident incrustation by the salts of the urine on the portion of the string that was in the bladder, while the incrustation is not so marked on that portion that occupied the urethra. There can be no question of the truth as stated. If the examination be made, it will be found that there is a bow-knot—a very simple arrangement—and the probabilities were that a considerable portion of the string, ten or twelve inches, had been passed into the bladder, and, of course, coiled up, and it became entangled in that way so that a knot was formed, and then, pulling on it, of course, drew the knot tight.

Dr. Pollak:—It would be interesting to inquire how the thong got into the bladder. I should suppose the man had stricture and used it as a bougie.

Dr. Fairbrother:—In the absence of a positive history in this strange case, I may mention masturbation as the most probable incentive for the introduction of this thong into the bladder. I remember a case where a piece of lead pencil, three inches long, was passed up the urethra for purposes of the sort. There is no accounting for the actions of persons thus infatuated; they are monomaniacs, rational in every other respect, perhaps. Such men are urged to acts of extreme absurdity and baseness by the morbid psychical state which dominates over them.

Dr. McPheeters:—Yes, and women likewise.

Dr. Stevens, Sr: I have had an opportunity of learning the facts in two cases of this kind. In one of them a man, laboring under stricture of the urethra, used a piece of lead about three inches long, which he had rounded and scraped so as to render it easy of introduction. It finally slipped from his fingers and passed into the bladder. Dr. McDowell operated upon this individual some three months after, and removed it from his bladder. The lead was in the center of a calcareous mass, nearly an inch thick, deposited from the urine. The patient admitted that he was a masturbator, and said that by introducing the cylinder

of lead, and suddenly withdrawing it, he could excite the coveted sensation. The other case was one of an individual who had been in the habit of introducing into his urethra the little shoots which grow around the base of the corn-stalk when it is about to tassel. These are five or six inches in length, without branches, quite smooth and rounded at the end, and well adapted for the purpose. One of these shoots slipped from his fingers one day but did not pass into the bladder. Dr Pallen, of Nashville, removed it with a little appliance that he contrived himself. The specimen was for a long time kept in the college and shown to the classes.

Dr. Hughes :—Cases of this sort seem to be more frequently met with in females than in the other sex. I recollect hearing Dr. Pallen, of Nashville, speak on this subject some years ago. He said the majority of them occur in women, specifying the case of a patient of his who introduced a hairpin into her urethra, whence it had passed into the bladder. "Waterfalls," said the doctor, by way of explanation, "were then in fashion, so that most probably she had used the hairpin to fasten up her waterfall." An interesting case is recorded by Dr. Richland, of a shepherd who had been in the habit of masturbating for a great many years, and who finally became consumptive, and unable through deterioration of health to excite himself. In a fit of despair he thrust a stick into the urethra, where it broke off, leaving a fragment in the bladder, and overwhelmed anew at what had happened, he split up his penis. These cases occur in a state of maniacal excitement, sometimes produced by satyriasis, or disappointment after attempted gratification.

November 30th, 1878.

Acute Œdema of the Larynx (?).

Dr. Hypes at the request of the Chair, read the following history of a case which he had mentioned at the previous meeting :

Case.—B. H——, a strong, athletic German; aged 37; occupation a brick-molder and fireman at a brick-kiln. First presented himself at my office, Tuesday, November 19, 1878. Save occasional attacks of fever during the past summer, had been previously healthy; said that while burning a brick-kiln two days ago, he had taken cold and brought the fever back on him. On examination found him suffering with catarrhal symptoms, and with intense congestion of the pharynx, without, however, any swelling of the throat or tonsils. I prescribed for him a cathartic with cinchonidia internally, and a gargle of muriate of

iron and chlorate of potash. Next morning, at 4:30, was called to see him at his house. Found him sitting in a chair looking quite comfortable; pulse, 96; breathing easy; but his wife said he passed a very restless night, at times almost suffocated for want of breath. His voice was clear but weak, and he seemed very much exhausted. Examination revealed bronchial breathing with enfeebled vesicular murmur; no râles; supposing he had an attack of asthma, I prescribed for him accordingly, promising to see him again about noon. At 1 P. M., upon visiting him I found that he had become rapidly worse, and that another physician had been called in. At this time, breathing was difficult and painful, as was also swallowing. Pulse, 100 and full; temperature, 100.5°; voice still clear, but weak; chest examination the same, except that the bronchial breathing was more and more marked, and vesicular murmur less distinct; slight swelling observed for first time on right side of the neck, about opposite the pomum Adami, where the patient located his pain. Finding remedies gave no relief I sent for Dr. Holland in consultation, who saw the patient with me, at 3 P. M. We agreed as to the trouble being of an inflammatory nature, and that tracheotomy would probably be necessary, but as his voice was still clear and blood apparently well aerated, concluded to try leeching him again in an hour, which we did at 5:30 P. M., his symptoms not being urgent; pulse, 106; temperature, 102° Fahr.; we left with the understanding that if the patient was not better by 8 P. M., we were to operate on the throat. On visiting him at that hour we found him dead.

The members of the family informed me that he had been sitting in the chair, but got up, went to the bed and tried to lie down again, but not resting returned to the chair, and in a few minutes fell back dead. He had died probably a quarter of an hour before I got there.

We used besides the remedies mentioned, hot water, hot lime-water, and also gave him a foot-brth, with sinoplasms and poultices to his chest; all, however, seemed to be of no relief to him. The case was a most difficult one to diagnose. The man's voice was clear, and, although his pharynx was congested, I do not suppose there was any great laryngitis, but I expected to find some œdema of the glottis, but Dr. Holland and myself could find no œdema of the epiglottis at least. We got a post mortem examination with some difficulty, that has revealed to us a very interesting specimen indeed, which shows as Dr. Wyman has very properly called it, I suppose, general cellulitis of the larynx. The parts are very much swollen, and there is a certain amount of congestion, which is chiefly on the right side. This proves to be simply enlarged glands with some cellulitis upon the parts external to the larynx. Here is also a normal larynx which Dr. Mudd gave me last Saturday night to exhibit along with it to show the contrast between them.

There was a peculiarity about his breathing that I never saw before. Swallowing was also difficult; he could not swallow a particle of medicine or water without having it come out of his nose.

Dr. Wm. Porter:—This is a case that none of us can estimate very correctly by experience, for it is fortunately very rare. It belongs to the class known as acute diffuse cellular laryngitis of an acute variety. This inflammation in the larynx, as elsewhere, begins in the cellular tissue. There is a rapid effusion of lymph which accounts for the great swelling. A difference between this and erysipelas of the larynx (which very frequently resembles it in many respects) is that the erysipelatous inflammation is first found on the surface of the mucous membrane, whilst this is found beneath it. When a post mortem examination is made of a case of this kind, and I may say that most of the cases die, you will find in the cellular tissue, serous sero-purulent or purulent infiltration, according to the stage in which the patient dies. This case is a typical one. The patient complains of being chilly and cold the first day, the next day is considerably debilitated, and after a little while he has what is like catarrhal laryngitis; his breathing becomes more difficult and finally greatly obstructed. The difficulty of making an examination, and the rarity of these cases has prevented the record of the laryngoscopic appearance of the larynx in any severe case. The patient dies either in the first stages from rapid infiltration closing up the larynx, or from spastic contraction of the muscles of the larynx on account of the nerves being involved by infiltration, or, in the third place, dies by the extension of the inflammation. I know of but few cases of this kind, one in my own experience, and two others on record; one recorded by Mr. Pollock, of London, who at the St. George's Hospital performed tracheotomy, and his patient lived. Another in the reports of Guy's Hospital. The third, my own, was of peculiar interest to me, and I will relate it very briefly: The man came under my care with the kindness of a colleague on the resident at the London Hospital. When I examined him I did not know what the trouble was. Some of the most able laryngoscopists of London were called in, but did not agree in their diagnosis. After a while the patient's breathing became so difficult, and there was so much infiltration that tracheotomy was decided on, which I performed some three days after the onset of the disease. I believed at the time that the case was one of erysipelas of the larynx. It was coincident after the operation was performed that an erysipelatous inflammation appeared around the external opening. The man was operated on Saturday, and died Tuesday. However, before death we found there was a friction sound over the cardiac region, and there was also bronchial complication. At the autopsy we found pericarditis, recent bronchial inflammation and the larynx was such a one as

this specimen probably would have been, had the patient lived some three or four days longer. That is, there was inflammation, but instead of being serous it was purulent, and little abscesses were found here and there. The erysipelas was evidently a coincidence, being accounted for, I suppose, by the fact that there was erysipelas in the ward. I will say for the comfort of the gentleman who presented this case to-night, that while tracheotomy might have given this man a better chance, and prolonged his life a little, yet it is not likely that he would have lived; he might have died more comfortably, but this inflammation, especially occurring about the cartilaginous structure of the larynx, kills very rapidly. In the case of my own, abscesses were found between the mucous membrane and the cartilages clear down to the bifurcation of the bronchial tubes. These had occurred, doubtless, after the operation had been performed. I hope Dr. Hypes will write a complete history of this case and place it on record in some of our journals. It is one with which his name will be associated.

DR. HYPES:—I would like to ask Dr. Porter, if, in the cases he relates, there was any trouble with the voice. A husky voice which is generally a characteristic of laryngitis. I noted that Flint and one or two other authorities which I consulted, state that it is a pathognomonic symptom.

DR. PORTER:—We must make an exception in this disease. Disturbance of the vocal function is not pathognomonic in this disease, because the inflammation is beneath the mucous membrane, and the region in which the vocal cords are found, may escape invasion. In this case the vocal cords are not involved at all. So we have in this case, contrary to the symptoms of acute inflammation about the larynx, perfect vocal function. In the case that I had there was some vocal trouble after tracheotomy was performed, even when the opening into the larynx was closed, but before the operation the man could speak well enough. This, however, was a sequence of the operation and not of the disease proper.

DR. PREWITT:—The case of Dr. Hypes recalls a case which I had under my care. About August 8th I was called to see a young lady in the afternoon, who was complaining a good deal of her throat, of some difficulty in swallowing and of some little affection of the voice as well. I endeavored to look down her throat to see if there was any inflammation, visible, but could not see any by depressing the tongue, but told her if she was not better next day I would examine her throat by the laryngoscope. She came to my office next morning and I did use the laryngoscope, and found considerable swelling on the right side of the larynx, and the right portion of the glottis and the epiglottidian folds, and considerable œdema. I prescribed for

her. I saw her again in the afternoon and found that the difficulty of breathing and swallowing was rather increased. I think that afternoon I made an attempt to scarify. During the night I was sent for in a great hurry to see her, about 2 A. M. I found that she had waked up with a sense of suffocation—could not breath. Her father had thrust his finger down her throat, and she got rid of a quantity of thick viscid mucous, which relieved her for a time. But while I was there she had one or two attacks of a rather spasmodic trouble about the throat, as if she would suffocate, and at one time I took out my instruments, thinking I would have to perform tracheotomy. I then used a bistoury and scarified the parts as well as I could. I had my laryngoscope with me and could see that the swelling had increased, but confined mostly to the right side. After that night there was no danger of suffocation, seemingly, that is, she had none of those very severe attacks of suffocation. They came on but were not so threatening, although she still breathed with difficulty and her voice was very much affected. About the second or third day after that I examined her throat and found, by aid of the laryngoscope, there was quite a swelling on the right side of the larynx, which I supposed to be an abscess, and I found that by depressing the tongue firmly I could see the upper portion of the swelling, and using the bistoury I opened it with a discharge of a large amount of pus, which, of course, relieved her very much. Now this probably was a cellulitis. Whether it was erysipelatous in character I do not know, but it certainly came very near suffocating my patient. There seemed to be a certain amount of sloughing on the margin of the larnyx on the right side.

Dr. Holland:—The point I am most interested in is how to carry the patient over the first stages of the disease. It seems that this patient died simply from œdema, the swelling around the larynx. How is this to be treated? I cannot see that it can be treated locally. In the first place I do not consider it possible to have examined this man with a laryngoscope because it was impossible for us even to hold the tongue down long enough to use the laryngoscope. In the second place the man could not swallow anything, neither could he gargle; the epiglottis on one side was decidedly infiltrated; hence when he went to swallow, the epiglottis was not closed completely, and some of the fluid would make its way into the larynx and irritate it. His breathing was entirely nasal; he kept his month closely shut, drawing back its angles and closing the teeth. Now how could that case be treated locally(?) he could not be treated constitutionally by the mouth, because I am satisfied you could not get him to swallow a sufficient quantity of medicine.

Dr. Moore:—I should treat such a case by a local extraction of blood, provided the state of the man admitted of it, and I

should depend greatly upon counter-irritation. So far as my experience goes in the treatment of the throat, a blister and proper depletory measures never fail to afford a certain amount of relief. I have used a blister in tonsillitis; and I should suppose it would have a decidedly good influence in a case like the one reported—better than any other local application.

DR. HYPES:—The patient was thoroughly purged before these symptoms came on. He came to my office on Tuesday; none of these symptoms manifested themselves until that night; then all the symptoms were so severe that we could do nothing for him. Nothing prescribed after 12 o'clock could be swallowed at all. The case was so rapid in its progress that it left no time for medication. We applied leeches, but they did no good, although the bleeding was profuse, and was kept up by poultices and even continued up to the time of death, which was some two hours after the leeches had been applied.

DR. KENNARD:—I will state in addition to what Dr. Moore has said that I would have applied mercury to the chest. Sometimes in bad cases of croup it has a decidedly beneficial effect. I should have tried putting my patient under the influence of mercury as soon as possible. I would have used mercurial ointment, or the oleate of mercury, which I prefer.

DR. WM. JOHNSTON:—I may have been one of those fortunate members who have seen those wonderful cases, but it seems to me I saw them forty years ago—very bad ones, too. Unfortunately for my practice, these patients have died. I believe the disease to be the result of exposure and suppression of the secretion of the skin whereby some material which should be exhaled is retained in the blood. Now, sir, we may have laryngitis instead, perhaps, or erysipelas or dysentery, dependent upon some cause manifesting itself in the weaker part of the organism. If the weaker part should be the fauces or the epiglottis, there would be an active inflammation. Now, sir, the practice I was taught was, "bleed *ad libitum*," and I have done it. I have opened both veins in the arms and bled my patients, but they died. I have equally purged them; I have tartarized them and blistered them, but they have died; I have cauterized also with a 40-gr. solution of nitrate of silver. Such is the practice I have pursued for the last five years, following it up with hot baths and quinine, and still my patients died. So far as I can see, we have not gained anything since I entered the profession, forty-six years ago. The destructive influence goes on so rapidly that we cannot arrest it.

DR. PORTER:—This case is not one of acute larnygitis. They are not uncommon, and the gentleman has doubtless seen many. This is infiltration *beneath*, not on the surface of the mucous

membrane. It is also *diffuse*, not circumscribed, as was doubtless the case in the instance mentioned by Dr. Prewitt. A case like this must not be confounded with ordinary acute inflammations of the larynx.

Dr. Rumbold:—I thought last Saturday evening that I had not seen a case similar to this, but I now remember to have had one quite similar to it. The patient recovered, and is now living in this city. He had been using the steam spray atomizer for three days. His first symptoms were those of an aggravated sore throat, one that produced considerable constitutional disturbance. When he came to me he was in a cyanotic condition, even the back of his hands were blue. Although he was supported by his brother, his gait was staggering. He was at once taken home and tracheotomy performed with the assistance of Dr. Niehaus. At the time of the operation he was entirely unconscious; for this reason no anæsthetic was administered. Three days afterward a large abscess formed on the left side of the pharynx, on a level with the lower margin of the velum palati. This was opened by Dr. Niehaus. Two days subsequent an abscess pointed and was opened about two inches below the opening made for the tube. Notwithstanding this the tube was taken out in the seventh week after the tracheotomy.

A peculiar circumstance connected with the introduction of the tube was that before I performed tracheotomy he could speak, of course, with difficulty, but after the tube had been in the trachea twelve hours, he could not produce a vocal sound. It seems that the rest given to the vocal cords had the effect of debilitating them.

In regard to Dr. Hypes' case I would not have delayed the operation of tracheotomy, especially if he was becoming the least cyanotic. In such cases I believe that the use of the steam spray atomizer will always be followed by an increase of all symptoms of impeded respiration. I am satisfied that I have had three patients upon whom I performed tracheotomy, who would not have required the operation had it not been for the injurious effect of the steam spray producer. The application that best united the feeling of my patient was the spray of sweet oil. He himself asked me to apply it; his wife had that morning given him some with a very good effect. At the present time I would make the application of vaseline by means of glass spray producers. All watery applications, especially if they are made by steam, tend to increase the thickening of the mucous membrane.

Dr. Wesseler:—The remarks of Dr. Rumbold, as regards the effect of steam, reminds me of a case that I saw seven or eight years ago. I was called to see a boy who had been blowing into a tea kettle, making bubbles. In doing so he inhaled a quantity of steam and burned his throat, which was in very much the

same condition as that described by Dr. Rumbold. I used a sweet oil emulsion, and he got well.

DR. BROKAW:—Did Dr. Rumbold examine his case with a laryngoscope? What was the appearance?

DR. RUMBOLD:—Yes; it had the appearance of a swollen mucous membrane; the epiglottis and the arytenoid cartilages had the same appearance; the glottis was so narrow that respiration could with difficulty be carried on.

DR. BROKAW:—The reason I ask this question is, that it seems that the laryngoscope is very difficult to use in these cases, and that even when we could use the laryngoscope, we can not distinctly recoginize the morbid condition. Then I say, how would we make the diagnosis in Dr. Hypes' case? I have no doubt that if the Doctor had remained there, he would have resorted to tracheotomy. But the question is, how are we to know what to do? The Doctor did not know of the inflammation of the cellular tissue beneath the mucous membrane, or whether it was œdema of the vocal cords.

DR. HOLLAND:—In Dr. Hypes' case laryngscopic examination was impossible, in consequence of the spasm of the jaws, and pain in attempting to pull out the tongue.

DR. RUMBOLD:—In the examination of cases like this, the act of drawing the tongue out is a very painful one to the patient. For this reason examinations of acute inflammations of the throat very frequently fail. The method that I prefer is to give the patient a tongue depressor in his own hand, and inform him how to use it. All the cases I have seen will bear examination if made in this way.

It does not require more than fifteen seconds to make a laryngoscopic examination quite accurately enough for our purposes. It is not necessary to make such an examination minutely, the main features only being required.

DR. BROKAW:—As I understood it, if we make the examination we would find narrowing, but no measures of relief could be instituted. We cannot relieve the condition by scarification. We can do nothing for it except by tracheotomy. If this had been done I think the man would have got well, if there were not abscesses forming. I do not think you could have examined that man's throat with the laryngoscope; he would close his mouth tightly, and would close his lips and teeth absolutely. I do not see how one could have time to introduce the laryngoscope long enough to make an examination. The vapor of warm water produces a transpiration from the mucous surfaces, and I can not see why the Doctor objects to that.

DR. RUMBOLD:—From the gentleman's statement about the

condition of the patient, that is holding his lips and jaws tighly closed, I think it would have been difficult to have made a laryngoscopic examination. But as to the effects of steam I am perfectly satisfied that I am correct. I think that nine-tenths of the cases I have seen, are such as have been injured by the use of steam inhalations. I have said years ago that the steam atomizer would go out of use, because its effects were far more deleterious than beneficial. It is not because the steams scalds, but because the mucous membrane absorbs the watery portion of the spray, and thickens it. Let a patient suffering from acute laryngitis inhale steam spray once in four or five hours, it will be found that his respiration is very much impeded, yet if we should spray the same kind of a case with an oily medicament, such as vaseline, making it pleasantly warm, just the opposite effect will be produced. In answer to the question what could be done for this case under consideration besides tracheotomy, I answer that I would have sprayed his throat with warmed vaseline. It has a pleasant effect; the patient can inhale it and we can see him exhale the spray from his lungs.

Pyromania at an Early Age.

Dr. Hughes here read a letter from Dr. Willis King, of Sedalia, describing the case of a child 10 years old who displayed a remarkable dread of fire, resisting all remonstrances and chastisements, and persisting in removing the burning fuel from the fire and carrying it out-doors, going to the fireplaces the last thing at night and the first thing in the morning, and getting out of bed during the night to see about the fires.

Frequently recurring malarial attacks had preceded the pyrophobic manifestations on the part of the child, and his mother was of a nervous, excitable temperament, though no history of ancestral insanity or other grave neuropathic disorder was given. The boy's dread of fire amounted to a mania. His physical functions were in the main normally performed.

Dr. Ford asked whether the boy had a congenital phimosis, and what was the condition of his urethra, etc.

Dr. Kennard wanted to know whether he indulged in masturbation.

Dr. Hughes:—I presented this case because it is exceedingly rare for a child of that age to manifest delusions similar to the one existing. The boy's delusion was that they were all to be burnt. A few instances are on record of pyromania at an early age, but no case like this—characteristically one of *pyrophobia*, has ever fallen under my notice, nor have I been able to find a similar one on record. As a rule, ideational insanity is very rare in children. Children are subject to a kind of delirium in fever, and to the affective forms of insanity, moral insanity, and

mental perversions associated with chorea. The present case I take to be a form of insanity dependent, perhaps, upon a masked epilepsy occurring during sleep. It is quite common among epileptics, both young and old, to have visions of flame and fire preceding the epileptic outburst, and sometimes these visions become persistent delusions. One of Dr. Hamilton's patients often saw a fiery cross, and another a locomotive headlight, preceding the epileptic attack. Lord Castlereagh's vision of a bright child appearing frequently at the foot of his bed, just as he awoke in the morning, may have been associated with a similar condition. Lord Castlereagh subsequently died of dementia.

In writing to the doctor who has sent me the details of this case, I took occasion to inquire into the existence of any reflex sources of cerebral irritation, and particularly whether the child had a phimosis. There is no direct connection between phimosis and this particular form of mental disturbance that I know of, but I conceived that the child might be troubled with epileptic seizures during sleep, and inquired concerning the existence of a phimosis, and also of enteric disorder, but received no answer. This case, at first sight, might not seem a very remarkable one, but when we consider that the higher nerve centers are not fully developed until a later age, and reflect upon the relations of insanity in general to childhood, the existence of this marked and singular intellectual disturbance in a child, seems quite worthy of record.

"Relations of Nervous Disorders and Insanity to Congenital Phimosis."

Dr. Ford:—The influence of affections of the prepuce in begetting various forms of nervous disorders by reflex agency is too well known at the present day to need more than a word of comment. But, for this very reason, it is highly important to make inquiries and examine our little patients with regard to the existence of such affections. We are much indebted to Sayre for bringing the matter prominently into notice as a cause of reflex paralysis and a variety of nervous troubles. Twenty-five years ago Fergusson directed attention to various local affections, inconveniences and dangers attendant upon a narrow prepuce, advising circumcision. A narrow prepuce alone does not always cause trouble, for the opening of the prepuce is normally quite too small to admit of the ready uncapping of the glans in young children. But, if the narrowness be such that the exit of urine is seriously impeded, adhesive balanitis is established by the irritation of urine retained about the glans, the bladder is irritated; and when the prepuce and glans have become soldered together, especially if a præternaturally small urethra and short frenum coëxist, the whole train of disorders known to depend upon these conditions is set in motion. Conditions of this kind induce restlessness during sleep, difficulty

in learning to walk, irregularity of the gait, besides suggesting masturbation. In the course of time graver nervous disorders are established, at first of an acute form, such as epileptiform convulsions, choreic attacks, etc.; and these eventually become chronic, exerting the well-recognized disastrous influences of chronic nervous disease upon the susceptible psychical organization of childhood. I have seen several cases of this kind, and have operated upon a considerable number of young children for the acute forms of nervous disease due to phimosis. Inquiry should be made in Dr. Hughes' case with regard to these matters, which, I am strongly inclined to believe, are the most common of all causes of nervous trouble in early life. Is there any abnormal degree of phimosis, any balano-preputial adhesion in this case, and how long have these conditions lasted? What, moreover, is the size of the urethra, and are there any symptoms of bladder trouble?

Dr. Kennard:—What Dr. Ford has stated is very true, but I can not believe that phimosis has ever produced insanity, and the case under consideration is undoubtedly of that character. Dr. Hughes refers to the fact that we find these forms of insanity in children but rarely. In this I concur. But that the manifestation of the insane condition should be that of a dread of fire, a pyrophobia, I cannot think remarkable, as Dr. Hughes seems to do. Children are amused by light and fire at a very early age, but will be greatly alarmed at the sight of a house on fire. In the presence of insanity, therefore, it can hardly be regarded as singular that the manifestation of the insane state should be associated with so conspicuous, interesting and so terrible an object as fire.

Dr. Hypes:—Dr. Ford's remarks upon the reflex influences of preputial troubles in children remind me of a case that came under my observation this summer. I was called to see a child last spring, troubled with epileptic attacks, which gradually became more serious during the summer, so that he was often attacked ten or fifteen times in a day. Finally, about a month ago, the attacks occurred as often as twenty-five times a day. I had the child in my office some weeks since, in the presence of Dr. Bauduy. While we were there Dr. A. P. Lankford observed that circumcision would probably be beneficial, and advised its performance. This was accordingly done. The day afterwards the child had some twenty-five or thirty spasms, but during the next two weeks the child was entirely free from spasms. After that interval, however, he was attacked with intermittent fever, which brought on a return of the spasms so that he had about two a day, and since then he has had one attack about every two or three days. Whether the operation was the immediate cause of relief I am not prepared to say positively, but upon operating we found a very small preputial orifice, and also adhesion of the prepuce to the glans. The child was four years old.

THE

SAINT LOUIS

Medical and Surgical Journal

VOLUME XXXV.

FROM JUNE TO DECEMBER, 1878.

THOS. F. RUMBOLD, M. D.,
EDITOR AND PROPRIETOR.

HIRAM CHRISTOPHER, M. D.,
ASSOCIATE EDITOR.

ESTABLISHED 1843.

SAINT LOUIS:
GEO. O. RUMBOLD & CO., PUBLISHERS,
1225 WASHINGTON AVENUE.

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The following are a portion of the subjects to appear in this department during the year 1879:

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Psychological Medicine, by Joseph Workman, M. D., Ex-Supt. of Toronto Insane Asylum and President of the Toronto Medical Society, Canada.

Diseases of Women and Children, by J. A. Ireland, M. D., Louisville, Kentucky.

The Anatomy of the Nervous System, by J. S. Jewell, M. D., of Chicago.

Thoughts on Certain Medico-Legal Questions, by Thad. M. Stevens, M. D., of Indianapolis.

Otology, by D. B. St. John Roosa, M. D., of New York.

Surgery, by John T. Hodgen, M.D., Professor of Surgical Anatomy, Fractures and Dislocations, in the St. Louis Medical College.

Electro-Therapeutics, by David Prince, M. D., of Jacksonville, Ill., and by A. D. Rockwell, M.D., of New York City.

Genito-Urinary and Rectal Surgery, by W. Hutson Ford, M.D., of St. Louis.

Anatomy in Art, and New Remedies, by Frank G. Porter, M.D., of St. Louis.

Ophthalmology, by Wm. Dickinson, M.D., of St. Louis.

Diseases of the Nose, Throat and Ear, by Thos. F. Rumbold, M.D., of St. Louis.

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AND

THEOPHILUS PARVIN, M. D., LL. D.,

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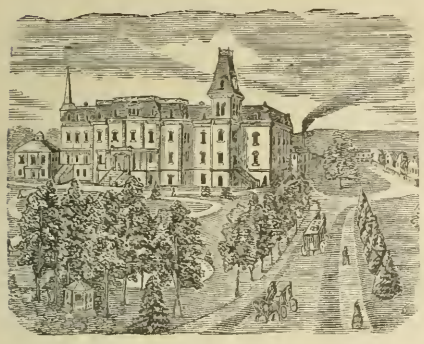

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